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References: 1 Hadgraft J, et al (2003) Skin Penetration of Topical Formulations of Ibuprofen 5%. An In Vitro comparative study. Skin Pharmacology and applied Skin Physiology Vol 16, No 3, pp. 137-142. 2 Whitefield M, D'Kane CJA and Anderson S (2002) Comparative efficacy of a proprietary topical ibuprofen gel and oral ibuprofen in acute soft tissue injuries: a randomized, double-blind study. Journal of Clinical Pharmacy and Therapeutics 27, 409-417. 3 source: IPI Infoscan: 52 w/e 12 June 2004 data.

London and PSNC divided over funding

Reid orders radical reform of MHRA

PPRS will have wider effects, says Sigma

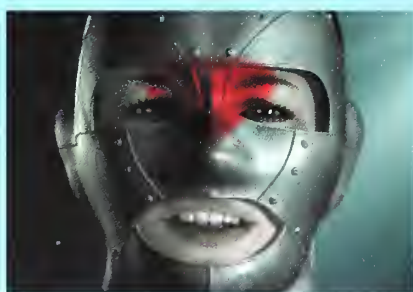
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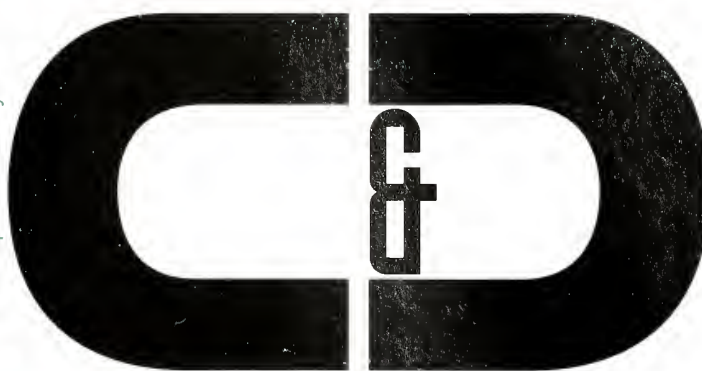
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CMP
United Business Media

'Contract should cover London weighting'

by **Adrienne de Mont**
ademont@cmpinformation.com

Nucare's managing director Mahesh Shah is concerned about the implications for contractors dispensing fewer than 2,000 items a month – particularly if the thresholds change in future.

"We would like these thresholds to be fixed and not subject to adjustments," he said. Small pharmacies in London, which often provided useful services to a transient working population, would be particularly badly hit.

"These pharmacies also have

much higher overheads than pharmacies outside the M25, so this is a double hit," he explained. "A London weighting should have been factored in."

He also thought the proposed exit payments were totally inadequate. Many pharmacists would still have to fund ongoing lease liabilities, so would need much better incentives to persuade them to leave.

While recognising the need to reward dispensing volume, Mr Shah thought there should be more help for small pharmacies to provide professional services,



particularly where there was a need to target the transient population.

Another concern was that the medicines use review payments did not compare with similar payments being offered to GPs. Under the government's *Agenda for Change* document, the principle was equal pay for equal work, he said.

Mr Shah was also disappointed at having so little time to make vital decisions on pharmacy's future. With issues such as control of entry still not totally clear-cut he would have preferred the ballot to have been delayed until after further discussion.

Contract begins move towards clinical role

The new pharmacy contract is the start of a process of moving towards a more clinical role for community pharmacists, NPA chief executive John D'Arcy has said.

It will strategically bind contractors into the NHS and create a framework for rewarding clinical services, Mr D'Arcy explained, and added that, over time, the balance between supply and clinical services will shift.

Mr D'Arcy said the NPA was fully supportive of PSNC and accepted that there had to be payment thresholds within the contract framework.

"The difficulty with this contract is trying to get something that everyone is happy with. In terms of small contractors and thresholds, we already have a threshold payment, which cuts in at 1,100 scripts and goes through to 1,600 scripts," he said.

"You have to make this contract work as best you can, and in recognising the needs of small contractors there is, built into the new contract, parachute payments to allow smaller contractors an

ability to move over a period of three years – in this case three years – to a position where they can



John D'Arcy, contract brings a shift in balance

benefit under the new contract."

He highlighted the fact that under the new contract, small volume pharmacies would get their current practice payment for three years, a repeat dispensing set up fee and transition payment, along with the possibility of payments for delivering advanced and enhanced services.

However, the NPA believes the exit payment should be moved from year one to year four, to allow contractors time to try and develop their business before they chose to leave.

Asked what contractors who may have difficulty in reaching the thresholds for the extra payments could do, Mr D'Arcy

said they should look at the business and decide whether they are going to take on the new contract or not. If they decide to continue, they may have to admit that the ability to grow prescription volume may be limited but this will be balanced by an opportunity to get involved in new services that were not there before.

● The Department of Health and the Royal Pharmaceutical Society have responded to concerns that small contractors could be disadvantaged under the new contract. The DoH said it had agreed a number of measures with PSNC to support low volume pharmacies, including protected payment of the professional allowance for three years, exit payments and continuation of the ESPS scheme.

The RPSGB, responding to concerns that pharmacies may close and deprive patients of access to services, said it would "watch the outcome of the ballot with interest" and that it would be "concerned if the new contract led to significant numbers of closures of pharmacies, but we have not yet seen evidence that this will be the case".

PSNC and LPC in contract row

PSNC is disputing a formula developed by North East London LPC to help contractors calculate how their future contract payment compare with present income.

PSNC head of finance Mike Dent said: "This contains a number of estimates and errors that might prompt contractors into making incorrect decisions."

But the LPC said it produced the tool because PSNC had not provided contractors with a mechanism to work out if they would be better off under the new contract. The LPC said it had made "clear reference to the usefulness of the tool and inherent limitations".

The LPC has posted the tool on its website and says it has had over 2,800 hits since last weekend.

But particular points that Mr Dent believes contractors should be aware of are: assuming all non OTC income is by default NHS prescription income; assuming that NHS income is as profitable as counter business; and comparing current income including buying profit with new contract figures that include fee income only.

However, NEL LPC says it has addressed these concerns.

PSNC issues oxygen alert

Contractors should attempt to reconcile the number of oxygen cylinders their supplier claims they have with their actual stock holding, but not enter into any financial arrangements, PSNC has said.

The announcement follows oxygen supplier BOC Medical asking contractors to complete an audit of cylinders and reimburse BOC for any missing items. Contractors who fail to do so will be charged rental on 1,360 litre cylinders from February 1, the company has said.

PSNC's Godfrey Horridge said: "We think this is an unhelpful proposal. The majority of contractors will have some cylinders missing, but they are not at fault, and the records of the oxygen companies are not 100 per cent accurate."

The closing date for tenders to provide domiciliary oxygen services was mid-November, and contracts would be awarded early next year. The new arrangements will come into effect next October.

For more information:

www.psnc.org.uk

PPRS will have wider impact, says Sigma MD

by Asha Fowells

afowells@cmpinformation.com

Cutting branded drug prices will reduce wholesalers' margins and affect the service offered to contractors, Sigma Pharmaceuticals managing director Bharat Shah has warned.

The 7 per cent price drop for branded medicines, agreed as part of the Pharmaceutical Price Regulation Scheme and effective from January 1 (*C&D*, November 5, p10) meant parallel importers would have less money to reinvest in their businesses. In time, this would lead to a reduction in the services offered to retailers, Mr Shah said.

Calling the PPRS agreement "a new enemy", Mr Shah said it had further compounded the problems wholesalers were experiencing in obtaining PIs.

Manufacturers imposing quota limits, the large number of parallel importers and the growing number of generic launches had already made such purchases difficult to get, he said.

"PPRS is another blow that is going to affect the margins of parallel importers and will have a negative effect on distribution," Mr Shah pointed out. But contractors would be worst hit, as they would have to continue buying available PIs, regardless of price, for fear of losing their discount clawback, he added.

When asked what action contractors should take, NPA chief executive John D'Arcy advised: "Pharmacists need to monitor their stock very carefully, and get the balance between overstocking and not being able to supply patients." But clarification on the reimbursement

arrangements was needed, he added. When asked for further information, a DoH spokesman said: "There will be no direct compensation from the Government to wholesalers or contractors."

PSNC finance head Mike Dent said: "Price changes set by PPRS member companies will be published in December. On receiving these, we will produce a detailed analysis of the impact of the changes, and will issue detailed advice for contractors."

"We will of course be having discussions with the DoH on the basis of this analysis. However, the new contract funding proposals offer contractors a secure £1.76 billion of income based on £500 million in buying profit based on independent pharmacy margins."

Call for GSL equality

Personal control should be interpreted pragmatically to ensure customers have equal access to GSL medicines, said the Company Chemists' Association.

A return to this interpretation would reflect custom and practice, should be possible within existing legislation, and any delay in resolving the issue was "completely unacceptable", it said.

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Module 10

Therapeutic drug monitoring

is included with this issue

Roadshow gets down to nitty gritty

by Adrienne de Mont

ademont@cmpinformation.com

Contractors attending PSNC's roadshows in Wales over the past week seemed positive about the new contract proposals, said Community Pharmacy Wales's chief executive Peter Haydn Jones.

"Mostly they were seeking clarification of various issues and we were able to allay some of their concerns," he said. About 120 contractors attended the roadshows in North Wales and mid and West Wales.

The contractors were concerned about issues affecting ESPS, but received assurance that CPW is working to resolve these issues. Others sought clarification on whether small pharmacies opening fewer than 40 hours a week would have to open for longer; it was suggested that LHBs would consider requests sympathetically.

Enhanced services were also discussed and some contractors

wondered if the LHBs would have the capacity to monitor the contract in terms of clinical governance.

The mood was in contrast to an unofficial roadshow held on Sunday by North East London LPC, whose members have been banned from attending the contract roadshows because of an ongoing dispute with PSNC.

Pharmacist Raj Radia said it was "frightening" the way PSNC had gone ahead and given contractors only three weeks to vote. "It's so demoralising," he said. "We're chasing numbers again. It's not the service-based contract we were expecting."

He said he would be worse off and thought the proposals were heavily biased in favour of the multiples. He wondered what would happen to the pharmaceutical service when small pharmacies closed, and added that he would vote no in the ballot.

Roy Winston, Collier Row, described the mood of the



meeting as "disgruntled", with contractors regarding the proposals as a *fait accompli* in favour of the multiples. He felt there weren't enough hours in the day for small pharmacies to make up the projected shortfall in dispensing income by concentrating on enhanced services – even if the PCT had enough money to pay for them.

The official PSNC roadshow in London on Monday was "quiet", according to David Kent, secretary, Camden & Islington LPC. He was concerned about the proposed exit payments and thought a more appropriate figure would be an average of the contractors' last three years' NHS income.

Over 200 contractors turned up for the South Mimms, Herts, roadshow only to find there was seating for 100. Some contractors walked out because they had come to discuss their concerns rather than hear how good PSNC was, said London pharmacist Derek Balon.

He thought contractors should be able to opt out after three years, not just one. It would be better to have a ballot on individual proposals rather than a yes/no vote on the whole package, he added.

● PSNC's remaining roadshows are: Bristol, Darlington, Nottingham and Llandrindod Wells on November 14.

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Product Information: E45 Cream. E45 Cream is a smooth emollient cream containing white paraffin 14.5% w/w, light liquid paraffin 12.8% and hypoallergenic anhydrous lanolin 1.0%. Uses: For the symptomatic relief of dry skin

conditions, where the use of an emollient is indicated, such as flaking, chapped skin, ichthyosis, traumatic dermatitis, sunburn, the dry stage of eczema and certain dry cases of psoriasis. Dosage and administration: Adults, children and elderly:

Apply to the affected part two or three times daily. Contra-indications: E45 Cream should not be used by patients who are sensitive to any of the ingredients. Undesirable effects: Occasionally, hypersensitivity reactions, otherwise adverse

effects are unlikely but should they occur, may take the form of an allergic rash. Should this occur, use of the product should be discontinued. Package quantities: 50g tube, 125g tub, 500g pump pack. Basic NHS cost: 50g £1.18, 125g £2.39, 500g £6.20.

Legal category: OTC. Product licence number: PL 03275/5904. Product licence holder: Crookes Healthcare Ltd, Nottingham NG2 3AA. Date of preparation: January 2002. Reference: 1. U & A data HCP 2003. CHC 844. Date of preparation: September 2004.

Standards framework proposed by NHS Wales

by **Asha Fowells**

afowells@cmpinformation.com

NHS Wales has proposed a common framework of healthcare quality and safety standards.

The consultation document, *A Statement of Healthcare Standards* outlines the assessment criteria and standards that will underpin the framework. The initiative aims to simplify and harmonise standards in all NHS healthcare providers, including independent and voluntary sectors. However,

the document will not contain all healthcare standards but will direct people towards relevant guidelines, national service frameworks and appraisals.

The four main principles are:

- simplify the existing array of standards

- include all healthcare settings
- ensure standards are comprehensive but are flexible with regards to implementation and delivery, and

- organise standards into four domains of patient experience,

clinical outcomes, healthcare governance and public health.

Comments should be sent to Taryn Ramsay, Healthcare Standards Consultation, Health and Social Care Dept, Welsh Assembly, 4th Floor East Wing Government Buildings, Cathays Park, Cardiff CF10 3NQ or to Taryn.Ramsay@wales.gov.uk by February 3. The framework will come into effect on April 1.

For more information:

<http://www.wales.gov.uk/keypubconsultation/index.htm>

Nottingham pharmacies run DUMP campaign

Nottingham pharmacists are encouraging patients to return unused medicines this month as part of an awareness campaign.

Nottingham City PCT has provided all pharmacies with special bins to support its 'Dispose of Unwanted Medicines Properly' (DUMP) initiative. The PCT has estimated that £500,000 of the £39 million it spends on prescription medicines each year is wasted on unused medicines.

In addition, GP- or pharmacist-led medication reviews are being promoted to patients, and the campaign is being supported by bus and tram advertising. The month-long initiative will be evaluated to examine the quantities and types of returned products and analyse the cost implications. This information will be used to improve future prescribing.

RPSGB responds to Shipman report

The RPSGB has published its response to the Shipman Inquiry's Fourth Report, which covers Controlled Drugs and pharmacy services.

Welcoming the recommendation

to inspect dispensing doctors and doctors' premises like pharmacies, the Society has suggested its own inspectorate takes a central role and proposes a "comprehensive scoping exercise" to develop a

new Controlled Drug inspection regime. In addition, GPs should prescribe only the lowest CD dose for their immediate family or themselves in an emergency, the RPSGB said.

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E45 Itch Relief Cream. E45 Itch Relief Cream contains Pramoxine HCl 3.0% w/w and Hydrocortisone 1.0% w/w. It is used for the treatment of pruritus, itching, and skin conditions where an anti-itching effect is required. It may also be used for the continued treatment and follow-up treatment of these skin diseases. Dosage and administration: Adults, the elderly and children: Apply to each affected area twice a day. The duration of treatment depends on the clinical response. Contra-indications: Patients with known hypersensitivity to any of the ingredients. It should not be used to treat acute erythroderma, acute inflammatory, oozing or infected skin lesions. Special warnings and precautions for use: May cause irritation if applied to broken or inflamed skin.

Patients with known hypersensitivity to any of the ingredients. It should not be used to treat acute erythroderma, acute inflammatory, oozing or infected skin lesions. Special warnings and precautions for use: May cause irritation if applied to broken or inflamed skin.

Pregnancy and lactation: There are no specific restrictions concerning its use during pregnancy, but it is not to be used on the breasts immediately prior to breast feeding during lactation. Undesirable effects: E45 Itch Relief Cream has been reported to cause a burning sensation, erythema, pruritus or the formation of allergic contact dermatitis. Allergy has also been reported. Package size: 50g and 100g tubes. MRRP: 50g £3.39, 100g £6.79. Category: GSL. Product licence number: 000909. Product licence holder: Crookes Healthcare Ltd.

erythema, pruritus or the formation of allergic contact dermatitis. Allergy has also been reported. Package size: 50g and 100g tubes. MRRP: 50g £3.39, 100g £6.79. Category: GSL. Product licence number: 000909. Product licence holder: Crookes Healthcare Ltd.

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Mawdsleys offers support on new contract

Wholesaler Mawdsleys has announced an extension to its services portfolio in response to the new pharmacy contract.

Mawdsley's 'Advanced Services Support Programme' has been designed to support its customers in developing and marketing advanced services in four key areas:

- premises suitability
- training and accreditation
- medicines use review recording and audit, and
- business case and marketing.

Leading the programme is the company's retail services director John Davies. He believes the new

contract "offers limited direct financial benefit, [but] it opens up enormous opportunities for pharmacists to market themselves within their local communities".

"There is little point offering extra services to patients on behalf of the NHS unless pharmacists are prepared to market them effectively. However, with the advantage of local knowledge and patient loyalty, independents should find themselves in a good position to take full advantage of these new opportunities," he said.

For details, telephone Michelle Biggs, professional services manager, on 0161 742 3300.

Scotland invests £1m to tackle health gap

Closing the gap between the rich and the poor is Scotland's biggest challenge, health minister Andy Kerr has said.

The Scottish Executive has

announced an annual investment of £1million for projects such as the Glasgow Centre for Population Health.

The centre will identify issues

causing the health gap and, with local people and health experts, find ways to close it.

Mr Kerr said: "We are investing in an innovative unmet

need pilot study in Glasgow and are supporting a huge range of other initiatives from across the Executive to tackle Glasgow's poverty and disadvantage."

Scratch resistance

The 'itch' of eczema is recognised by doctors and sufferers alike to be the worst symptom of the condition, causing sleep disturbance in 85% of cases.¹

We've drawn upon 50 years of skincare experience to formulate E45 Itch Relief Cream specifically to help ease this distress.

Moisturising urea and local anaesthetic lauromacrogols combine in a dual action formula to soothe the itch whilst hydrating and smoothing the affected skin.² These therapeutic benefits are delivered in a well tolerated and highly acceptable emollient cream.³

A "very good" or "good" improvement in skin condition was measured in 74% of patients.³

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CCA COMMENT

Time to take centre stage

This week sees the launch of a regular column by The Company Chemists' Association Ltd (CCA). It will highlight issues it sees as important to the future of community pharmacy, and dispel a few myths, says Georgina Craig

For those of you who don't know its history, CCA has been around a long time. It was formed in 1898 to promote the interests of corporate bodies engaged in retail pharmacy. It has never had a high profile, preferring to work behind the scenes to shape legislation and the professional environment.

However, member companies now recognise that the time has come for CCA to increase its profile. Not surprisingly, there is a lot of suspicion about CCA's motives. But by becoming more involved in the debate, CCA hopes to demonstrate that most of the time we have more in common with independent contractors than that which divides us.

This is especially true now. If the vote for the new contract is a yes, then we will have just four months before going live in April 2005. What is more, primary care trusts, which are critical to the successful implementation of the new framework, are still immersed in the general medical services (GMS) contract – and in many cases, concerned that over-achievement against its quality targets is going to leave them struggling financially. Then they have a new dentists' contract to think about as well.

Despite community pharmacy's potential to help PCTs meet their targets, many PCTs are too focused on the "must dos" to look at the big picture. The Department of Health, NHS Confederation and NatPaCT are producing a range of resources to ensure the implementation process is made as easy as possible, but with so much at stake the onus is going to be on contractors – and, specifically, local pharmaceutical committees (LPCs) to engage positively and show the value they can bring to local planning forums.

PCTs are accountable for public health and, as such, must ensure they have transparent processes for



commissioning services. But LPCs' success in influencing PCT decision-making, and importantly the budget for locally commissioned pharmacy services, will be mixed.

The next few years are crucial for LPCs. They may become highly influential, driving forward the pharmacy development agenda and central to all activity at local level – or they may find themselves sidelined as PCTs set up their own systems for local consultation and negotiation with pharmacy contractors.

It will be a challenge – the numbers alone tell us that. There are only 87 LPCs in England – and between them they have to engage with around 300 PCTs – so that's at least three each. They are already spread very thin.

CCA wants LPCs to remain the key organisation for pharmacy contractors – and to that end, is investing significant resources to ensure that CCA representatives are able to make a valuable contribution to the LPCs they sit on. We will do all we can to support LPCs – and that can only be a good thing for all pharmacy contractors, don't you think?

Georgina Craig is head of communications and partnership development at the CCA

ARTICLES

Boots defends pharmacists

by Fiona Salvage

fsalvage@cmpinformation.com

Boots The Chemists has defended its pharmacists against accusations made in the *Mail on Sunday* over its cholesterol testing and sales of Zocor Heart-Pro.

In a statement, Boots said any testing system on biological samples is subject to variation. It highlighted the tests had been carried out over a period exceeding a month, in different circumstances and by different testers. "We are investigating the measurement reported to confirm that all QC tests were completed properly and were within an

acceptable range," Boots said.

The company concluded: "It is an accepted fact that healthcare professionals including GPs often vary in their opinion of treatment for an individual. The general consensus however that all healthcare professionals are agreed on is that statins are an effective way to reduce your risk of heart disease."

The *Mail on Sunday* investigation sent a 63-year-old woman to five Boots stores for cholesterol tests. Her results ranged from 4.3 to 6.1mmol/L and the advice included lifestyle changes, taking fish oil capsules, and OTC simvastatin.

MEDICALS

Pulmicort inhaler recall

The Medicines and Healthcare Regulatory Agency has issued a recall notice for Pulmicort inhalers, due to a small number of devices failing or needing a higher than normal pressure to actuate.

The affected Pulmicort LS batches are CD626, CC349,

CB877 and CD112. The affected Pulmicort 200mcg inhaler batches are CB875, CF165, CB260, CD316, CC778, CC422 and CD801. In addition, hospital-only 100 dose Pulmicort inhalers bearing the batch number CB878 and Pulmicort + Nebuchamber batch CD915 are affected. No parallel import product batches are being recalled.

Pharmacists have been asked to quarantine and return any affected stock to their supplier.

For more information:

AstraZeneca UK Ltd, Medical Information Department
Tel: 01582 836836

Correction

The Vantage dispensing assistant course is currently awaiting accreditation by the College of Pharmacy Practice (C&D November6, p8).



Georgina Craig MP (right) and fellow pharmacist Selma took part in a community pharmacy survey. They are pictured in the community pharmacy in the Croydon constituency (Harrow, Harrow).

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Nothing works faster than Zovirax[®] Cold Sore Cream to treat the tingle or bust the blister of cold sores.^{1,3,4} Zovirax helps soothe pain within an hour of application⁵ and cuts cold sore healing time by up to half.*^{1,2} You and Zovirax together – what a great team.

*Compared to no treatment



aciclovir

Zovirax Cold Sore Cream Product Information

Composition: 5% w/w aciclovir in water miscible cream base. **Uses:** Treatment of Herpes Simplex virus infections of the lips and face (cold sores). **Dosage and administration:** Apply 5 times a day for 5 days. It is important to start treatment as early as possible after the start of infection, ideally during the tingle phase. If healing has not occurred, treatment may be continued for up to an additional 5 days. **Contraindications:**

Known hypersensitivity to aciclovir or propylene glycol.

Precautions: Only to be used on cold sores on the lips and face. Do not apply inside the mouth or in the eye. Do not use for herpes infections of the eye or the genital area. Do not use if the patient is under the care of a doctor because of a weak immune system. Consult doctor if pregnant or

breast feeding. **Side effects:** Transient burning or stinging may follow application. Mild drying or flaking of the skin has occurred in about 5% of patients. Erythema, itching and contact dermatitis have been reported rarely following application. **Legal category:** P. **Product licence number:** 00003/0304. **Product licence holder:** The Wellcome Foundation Limited, Greenford, Middlesex, UB6 0NN, U.K. **Further information available on request from:** Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 2 g tube - £5.99; 2 g pump - £6.19. **Date of last revision:** March 2004. Zovirax is a registered trade mark of the GlaxoSmithKline group of companies.

References:

1. Spruance SL *et al.* Antimicrob Agents Chemother 2002; **46**(7):2238-43.
2. Spruance SL. Seminars in Dermatology 1992; **11**(3): 200-206.
3. Van Vloten WA *et al.* J Antimicrob Chemother 1983; **12**(Suppl B): 89-93.
4. Fiddian AP *et al.* Br Med J 1983; **286**: 1699-1701.
5. Data on file, GlaxoSmithKline, 2001.



GlaxoSmithKline
Consumer Healthcare

In response...

PSNC chief executive **Sue Sharpe** responds to concerns about small pharmacies

The new contract roadshows are coming to an end and the contractor ballot has another week to run. Contractors have made, or are making, the decision whether to vote for the new contract.

There is a general recognition of the far greater financial security that the new funding proposals offer for the overwhelming majority of pharmacies. This is what drives the whole of the new arrangements. The insecurity of present NHS income, specifically that from purchase profits, needed to be addressed, and PSNC has been settled in its determination to develop secure income streams.

The Government is well aware of supply chain profits, witnessed by its recent actions to remove £300 million from four generic molecules. The funding negotiations, which have been extremely difficult, have secured fair funding for the services we

are proposing to provide.

This, PSNC has established by using expert financial analysts to build on the evidence derived from the joint PSNC/DoH cost inquiry and the model for costing the new contract services. That, of course, is why the committee, comprising contractors, most of them independents, voted unanimously in August to accept the final offer from the DoH.

Concerns have been expressed about the distribution proposals and there have been some calculations aired that are wrong – those suggesting that pharmacies will be worse off in terms of fees and allowances. Each contractor can assess the average fees and allowances for his volume of prescriptions using Annex 4 of the new contract book published by PSNC; they exceed those today. What is more difficult for the contractor, and impossible for PSNC, is to know just how much income is derived today from

purchase profits and how much there will be in the future. This will depend on the contractor's own business deals.

Because the purchase profit income will be based on purchase profits available to independent pharmacies, the new arrangements ensure that independent pharmacies can receive fair funding. Some contractors have been worried about the details of the changes to the *Drug Tariff*, but this is not so important. What is vital, and is agreed, is the amount that will be provided to independent pharmacies through purchase profits, and mechanisms will ensure this is available to them.

In last week's *C&D* the position of the small number of contractors (estimated at no more than 7 per cent of all contractors for 2005-06) dispensing fewer than 2,000 items was aired. They will all, next year, receive more money from fees and allowances than they do today.

The actual position depends first on whether they are ESPS pharmacies. If so then they will continue indefinitely to receive additional funding.

Then there are pharmacies dispensing fewer than 1,100 items. They do not receive a professional allowance under the present contract.

Pharmacies dispensing between 1,100 and 2,000 items per month will see improved income levels for the first three years of the contract, while the protected professional allowances apply. Thereafter, if they have not been able to develop their NHS business, and have not opted to take the exit payments or applied successfully to become an LPS pharmacy, they will see a significant drop in income. They will want to take stock of what the new national contract can offer them.

Of course, unless these

pharmacies have substantial income other than NHS funding, they do not today have profitable businesses, as there are large fixed costs for a pharmacy business, principally for staff.

There is a limit to what a national contract can do to address all local circumstances, and this is where the PCT's powers to contract using LPS assists. Contractors, if they decide that this new national contract is not for them, can seek to become LPS pharmacies. PSNC is working with the Department of Health and the NHS Confederation to develop a standard form LPS for low volume pharmacies that provide valuable services to their local populations, even though they have limited patient numbers. Alternatively, a specific LPS may be the solution.

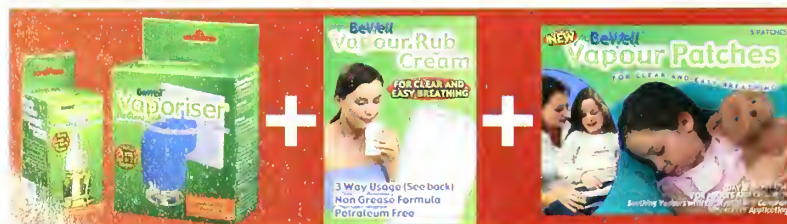
The Government, as was made clear at the PSNC conference last week, needs to ensure that NHS spending offers value for money for the taxpayer, and it is concerned about paying the high fixed costs for low dispensing pharmacies. It is also concerned about the impact of high levels of funding for low volume pharmacies on overall pharmacy numbers. Too many new openings, taking advantage of the control of entry relaxations, would depress the funding for other pharmacies. The fair funding we have fought to achieve would become less than fair if spread too thinly.

PSNC considered the proposed distribution arrangements very carefully. Great efforts have been made to provide the best possible funding and future security for the greatest proportion of contractors, and to offer options for the small number of contractors that the new national contract cannot protect. We believe we have succeeded, and that we have a fair, secure and rewarding contract for the future



Too many new openings, taking advantage of the control of entry relaxations, would depress the funding for other pharmacies

Sue Sharpe



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Our question to pharmacists this week was: What is your opinion of the US presidential election?

Comment

from the Editor

"I don't really know much about it"

Eddie Ho,
Washington

"I think it was inevitable, but I was a little dismayed"

Anonymous,
Boston

"I'm not that surprised. It's not a particularly good thing for the world, but I don't know if the other person would have been any better"

Philip Hawkes,
Birmingham

Unsurprisingly, the new pharmacy contract continues to dominate the news agenda.

Nucare has called for the contract's thresholds to be fixed, described the exit payments as inadequate and suggested that the contract should have included a London weighting. Over in North East London, the LPC and PSNC have become embroiled in a row over how accurate the LPC's 'contract calculation tool' is. Further, our contract roadshow and PSNC conference coverage reveals that contractors are far from unanimous in supporting the funding model.

PSNC chief executive Sue Sharpe addresses the key issues in *C&D* this week. She argues that the new contract provides greater financial security for the majority of pharmacies; is built on evidence from the cost inquiry; and secures fair funding for the proposed services. Tackling the concerns of low volume pharmacies, she admits that there is a limit to what a national contract can do to address all local circumstances.

But while the small print needs scrutiny, it is important not to lose sight of the big picture. The opportunity to fundamentally restructure the way pharmacy services are delivered and funded is one that comes infrequently.

Pharmacy has long sought a contract that rewards new services alongside the supply function. It has finally arrived. Yes, there will be winners and losers, but if the opportunity is not taken it will not be offered again soon, and contractors will quickly realise the status quo is not a viable option for future prosperity.

The new contract is a stepping stone to the clinical role the profession deserves and contractors should bear in mind that it's the direction of travel they are being asked to vote on, as much as the income that comes with it.

If the opportunity is not taken, it will not be offered again soon

Your views

Mike Dent, PSNC's head of finance, clarifies some contract details

To avoid errors, go by the book

PSNC is working hard to communicate the services and funding detail of the proposed new community pharmacy contract. It has published the book, put information on its website and is holding roadshows.

We recognise that this is a major time of change for contractors and have gone to great lengths to make information available to assist with their decision-making on the new contract. It is particularly important that contractors are clear about the income they are due under the new funding and distribution arrangements.

We are concerned that some contractors may be misled by the



information on funding for the new contract that is currently published by the North East London LPC. This contains

a number of estimates and errors that might prompt contractors into making incorrect decisions.

Points to be aware of include:

- Assuming all non OTC income is by default NHS prescription income.

- Assuming that NHS income is as profitable as counter business.

- Inviting contractors to make a comparison between current

income including buying profit with new contract figures that include fee income only.

It is only by working in detail through the NEL published material that contractors can understand how buying profit should be factored into their calculations.

A contractor who is able today to make the level of buying profit implicit within the NEL calculations will be able to secure higher levels of funding under the new contract.

We suggest contractors base their calculations on the tables provided in the PSNC book, supplemented by their knowledge of their own business.

HOSPITAL
REPORTContract
problems?
You should
be so lucky

TOPICAL REFLECTIONS

Look on the bright side of the contract

You can't please all the people all the time, but when it comes to pharmacists it seems there are some people you can never please. Of course everyone would like to write their own individual contract and their own wage slip but, in the real world, one has to accept when things are as good as they get. Anyone who thought the new contract would deliver great riches for old rope has been living in a fool's paradise.

Some low volume pharmacies will be worse off under the new contract, but at least they have the opportunity to get back on terms if they get their teeth stuck into advanced and enhanced services and standard form LPS. Has everyone forgotten that £300m had been simply 'taken' from our generics payments over the last 12 months? That's about £20,000 from each pharmacy that disappeared at short notice and without any negotiation. Is that the way we want to carry on?

Anyone dispensing fewer than 1,100 items per month will apparently see a 4.6p cut in their item fee. That's about £46 per month. Or two medicines use reviews. Big deal. Why are there so many pharmacies dispensing hardly any prescriptions in Chelsea and Westminster? Because they survive on

private prescriptions and counter sales and I'm sure they will continue to do so. 'Essential' low volume pharmacies will continue to be funded under the ESPS scheme, but why should the NHS donate large sums to pharmacies that run their NHS operation as a sideline to a more lucrative business?

The new contract does not drastically shift the emphasis from dispensing to services, but I understand that it is flexible enough to alter this balance in future. There would have been a few more complaints if we were to be paid only for services and little or nothing for dispensing. Contractors have always been paid for dispensing and they cannot change their whole operation overnight. I think everyone, if they were honest, would want us to ease gently into a major practice change.

Of course we must fight for everything we can get but, while I would hate to sound like a spokesperson for the DoH, this contract really isn't too bad. And anyone who votes 'no' should consider that it will probably be imposed anyway. If the might of the pharmaceutical industry cannot prevent the imposition of a 7 per cent cut in the PPRS, what chance has PSNC got on our behalf?

By the time you read this, the result of the ballot on Agenda for Change will have been announced. Whether it returns a yes or a no vote, uncertainty will be the order of the day.

If there is a no vote, the effect on the pay modernisation programme is unknown. Most unions have voted for the package, with the exception of the Society of Radiographers who delivered a no vote. How the Government would react to a negative vote is unknown. It has always stated that there is no plan B.

If there is a yes vote, and the package goes through, then there is the uncertainty of where on the pay spine your post will be matched. At least you know that you will not lose out monetarily in the short term, although longer term, protection is merely a freeze on current salary and will

Most of the staff
in the early
implementer trusts
matched at the
point they
thought they
would

therefore effectively be a slow reduction due to inflation.

Will aspirations be met? Word from the Guild of Healthcare Pharmacists is that most of the staff in the early implementer trusts matched at the point they thought they would. Outside the EI trusts there are, however, likely to be a significant number of staff seeking a review of their matching as they fail to get the banding they expect. I historically, some jobs have been graded more highly in areas where recruitment is difficult than in places where obtaining staff is not a problem. These staff are likely to be the ones most unhappy with the outcomes. It remains to be seen how many there are.

Written by a senior hospital pharmacist

Dangerous decision by Novartis

Novartis's apparently motiveless decision to market Scopoderm TTS patches solely through Boots for its first year is deeply divisive and sets a dangerous precedent (*C&D*, November 6, p10).

Surely this is unethical, if not illegal. Manufacturers are entitled to sell other items of commerce through whichever channels they wish, but medicines should be available to everyone who needs or wants them. Imagine the outcry if a manufacturer decided to make a prescription medicine only available through certain pharmacies. When the MHRA granted Scopoderm its Pharmacy licence it must have been on the basis that this is a useful medicine for everybody except those excluded for clinical reasons. While most people can get to a Boots store, not everyone can and these people will be denied access to a full range of medicines.

This is a valuable product and I feel cheated of the opportunity to offer it to my patients. Most people who purchase the product during its first OTC year will undoubtedly return to Boots for further purchases. Unless Novartis's marketing tactics change significantly after this year, demand at independent pharmacies is likely to be minimal.

But if the OTC product suffers the same availability problems that beset the POM version for years, this is something that is only ever going to be available from time to time anyway.



Please e-mail your views to chemdrug@cmpinformation.com

Society responds to CPD concerns

At a time when many pharmacists understandably have concerns about the introduction of CPD it is unfortunate Hobson's Choice (C&D, October 23, 2004 by David Temple and Guy Thompson) contained factual inaccuracies and wrong inferences about the Society's CPD system. Your readers will find it helpful if some of the points made are put right.

CPD will be a professional requirement from January 1, 2005, and will be a statutory requirement when the section 60 order comes into force later in 2005. The Society first started sending out packs to facilitate CPD and "rolling out" a training and support programme in October 2002. So far we have trained close to 650 people from the NHS and other organisations. The Society's local branch network has also been given access to trained CPD facilitators who are available to attend

and support local meetings.

In their article, David Temple and Guy Thompson say that consultations undertaken by the Society on CPD do not appear to have influenced the development of policy. This is simply wrong. A major consultation undertaken by the Society on CPD in early 2003 resulted in nearly 8,000 responses. The results were published and showed that a majority of the profession were in favour of all of the proposals for CPD, with the exception of one. Members said that they did not like the use of the terms "active" and "inactive" to describe pharmacists who will or will not have to do CPD. They said that they preferred the terms "practising" and "non-practising": this was adopted by the Society.

The Society will consult again in 2005 on the detailed CPD rules and standards that will be a consequence of the forthcoming section 60 order.

The question of whether the Society's system is less flexible than the Health Professions Council's (HPC) is one of interpretation. However, I question the statement that "this [HPC's] model offers considerably more flexibility" than the documentation required by the Society. The HPC requirement to maintain an ongoing 'free-form' portfolio, to write a 500 word practice history and a 1,500 word reflective statement is surely more onerous than the two or three sentences required to address the questions in the Society's recording format?

In the first phase of the Society's CPD pilot, launched in 1999, pharmacists were invited to record their CPD in a format of their choosing. It was found that those who did not choose the Society's more structured format did less well when their CPD was reviewed. The conclusion we drew

was that a more structured format that asks direct questions is more likely to elicit the information to determine whether someone has met the required standard.

Mr Temple and Mr Thompson refer to the HPC's proposal to randomly select first just 5 per cent and then 2.5 per cent of its members' CPD records and state that this is because the HPC trusts its members in the matter of CPD. They also suggest that the HPC's review of CPD records will allow for more meaningful and detailed feedback. However, there is a need for professions to be able to demonstrate that practitioners have taken the appropriate steps to keep their practice up to date: the submission and evaluation of CPD records is an important and visible way of doing that.

The Hobson's Choice article also misrepresented the nature of the Society's review and feedback system. It claimed that the online

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system has been designed to 'allow automated assessment using computers'. *CPD* readers may have been given the impression that a computer will decide whether or not they have met their CPD requirements and be allowed to continue to practise. In fact, the computer does only the simple and repetitive aspects of the CPD review, such as calculating the number of days' difference between when a learning need was identified and the target date for completion. This provides some measure of the extent of longer-term planning in a CPD record, with a view to providing some meaningful feedback.

The selective use of information technology allows the Society to use people where they add most value, for example in judging whether an objective is specific, measurable, achievable and relevant.

In relation to the involvement of lay people as reviewers, Mr Temple and Mr Thompson are

wrong to state that the majority of reviewers are not pharmacists. In fact, the split is about 50-50. We have worked closely with the Statistical Services Centre at Reading University to compare the consistency of reviews between individual reviewers. The statistics show that it is factors other than whether someone is a pharmacist or not that determines someone's appropriateness as a reviewer. In fact there is strong consensus between the majority of pharmacists and lay people about the qualities found in CPD records. Consensus seems to us an essential principle in taking any reviewing system forward.

In the event that a review indicates that someone is borderline with the standards, the record will first be reviewed by two other reviewers, one of whom will be a pharmacist. If the majority of reviews indicate they have not met the standards, targets for improvements will be set and time and highly skilled one-to-one

support will be provided to help make those improvements. In the unlikely event that those improvements are not achieved, the case will be sent to the CPD Committee for consideration and will draw on both professional and lay input.

I am unsure as to why the authors believe that there should be any difficulty in linking employers' and the Society's CPD systems. Should any employers be experiencing such difficulties I suggest that they contact us so that we can work together to take this forward, as we have with many others.

Of course, the very great majority of pharmacists have nothing to worry about. If they address the questions in the recording format and follow the good practice advised in Plan & Record, they will simply receive constructive feedback.

Should any pharmacists find themselves with questions and concerns about CPD, I suggest

they contact one of our CPD facilitators or myself.

Taking the first step is often the most daunting but experience has shown that recording CPD can quickly become second nature.

Fred Ayling,
CPD Officer,
Royal Pharmaceutical Society.

Hobson* rules, OK

It is a peculiar aspect of our contract that one party, the secretary of state, has absolute authority to change the specifications and payments at any time for any or no reason, granted by NIS (*Pharmaceutical Services Regulations 1992 18(1)*).

He does not have to consult (though he does) or negotiate (though he has often pretended to). The new contract will require amendments to this legislation,

Continued on page 18 ►

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Coming Events

◀ Continued from page 17

incorporating new terms of service but I would put my shirt on this clause remaining unchanged.

The published terms of the new contract show that a new price has been agreed and the arrangements for distribution determined.

We are being urged to accept the contract because there is no alternative and the new terms are non-negotiable.

They may indeed be so but they are NOT unchangeable by Regulation 18(1).

Everything within the *Drug Tariff*: drug prices, discount scales, fees, allowances and thresholds are subject to the command of the secretary of state.

The terms of service themselves will be subject to scrutiny and review by both Houses before new regulations can be enacted. So contractors should not think that either what they see is what they will get or that they are impotent to affect the changes proposed.

All the facilities of public debate and lobbying will be available despite the ballot result. Such lobbying will be helped if the

ballot result is close, I would therefore urge all independent pharmacists to vote no, to register their concerns in a meaningful manner and reject the fatalistic mindset being wished upon them.

Alan Castell,
community pharmacist,
Barking.

● Hobson: 17th century Cambridge stable owner, always had a horse available for hire, one horse, the one nearest the door, which you took or walked, hence "Hobson's choice."

IVAX answers Qvar questions

Subsequent to the recent launch of Qvar Easi-Breathe, there have arisen a number of issues that need clarification. These issues particularly concern the dispensing of breath actuated inhaler products on prescriptions that have been written generically.

The current situation to be clarified is such: there is only one CFC-free beclometasone inhaler drug licensed in the UK, this being Qvar. This is available as either an MDI, a breath actuated Autohaler or a breath actuated Easi-Breathe.

For prescriptions that are written as beclometasone breath actuated inhaler CFC-free, the pharmacist therefore needs to ascertain the intentions of the prescriber as to which device they have requested.

This is the same as has been previously for prescriptions written for salbutamol 100mcg breath actuated inhalers CFC-free, to which again the pharmacist needs to ascertain whether the prescriber intended the dispensing of either an Autohaler or an Easi-Breathe device.

This is clarified in the *Dictionary of Medicines and Devices (Dm+d)* at the Prescription Pricing Authority, which

designates which actual medicinal product (amp) can be dispensed against a virtual medicinal product (vmp) or generic description.

● Generic prescriptions for salbutamol 100mcg breath actuated inhaler can be met with either Airomir or Salamol Easi-Breathe.

Generic prescriptions for beclometasone 50 or 100mcg breath actuated inhaler CFC-free can be met with either Qvar Easi-Breathe or Qvar Autohaler.

● The other significant issue that has arisen is a reminder that ordinary beclometasone prescriptions for either a standard MDI or breath actuated device are not directly interchangeable with Qvar MDI, Autohaler or Easi-Breathe.

Qvar is a reformulation of ordinary beclometasone and as such differs from ordinary beclometasone as its smaller particle size means more Qvar gets into the lungs than ordinary beclometasone.¹

Qvar has the same clinical effect as ordinary beclometasone at half the dose.²

The advice is therefore to take extra care in the decision-making process as to which inhaler device to give on a generic prescription for both beclometasone,

beclometasone CFC-free and salbutamol so as to ensure that patients get the correct device and drug at the correct strength in the device that the prescriber wished to prescribe.

References:

1. Leach, C. *Effect of formulation parameters on hydrofluoroalkane-beclomethasone dipropionate drug deposition in humans.* *J. Allergy Clin Immunol* 1999; 104: S250-252.
2. CMO update no 17 Feb 1998.

IVAX Pharmaceuticals.

Clarification

In last week's interview about Your Portfolio with Alistair Marsh, head of pharmacy and retail services at UniChem, (*C&D*, November 6, p20) we referred to the range of programmes being developed linking in to national health awareness campaigns.

The ones quoted are still being developed, but UniChem says that programmes dealing with diabetes, coronary heart disease and eczema are ready.

UniChem is giving customers a credit for use in obtaining access to added value services rather than a voucher system.

NOVEMBER 15 RPSGB Southampton & District Branch

Meeting on *Dermatology – new developments*. Speaker, Professor Peter Friedmann. Venue – The Rose Road Assoc. Bradbury Centre, 300 Aldermoor Rd, Southampton at 7.30pm.

NOVEMBER 16 RPSGB East Metropolitan Branch

Joint meeting with Barking & Havering Branch on *CPD – What you need to know*. Speaker, Caroline A Saul at Our Lady of Lourdes Parish Centre, Cambridge Park, Wanstead, London E11 2PR.

RPSGB Reading & District Branch

Meeting on *New therapies in dermatology*. Speaker, Dr Walkden, consultant dermatologist at the Royal Berkshire Hospital, Trust Education Centre. 7.30pm for 8pm.

RPSGB South Cheshire Branch

Meeting on *Medicines management*. Speaker, Professor Theo Raynor, University of Leeds. Venue – Fourways Inn, Delamere, Northwich, 7.30pm meal, 8pm meeting.

NOVEMBER 17 Joint meeting RPSGB and British Society for the History of Pharmacy.

A pharmaceutical history of radiology, by Dr Adrian Thomas. Refreshments at 5.30pm, meeting at 6.30pm at the Society's headquarters, 1 Lambeth High Street, London SE1 7JN. Non-members are welcome.

NOVEMBER 22/29 RPSGB Oxfordshire Branch

Chiltern Regional Lecture: *A political view of pharmacy*. Venue – GSK, Stockley Park. For further details e-mail: sgshelley@ukonline.co.uk

I needed to free up my time in the dispensary. your portfolio is funding the quality training that will make this possible.

Jenny Parkin, Nories Pharmacy, Horsham

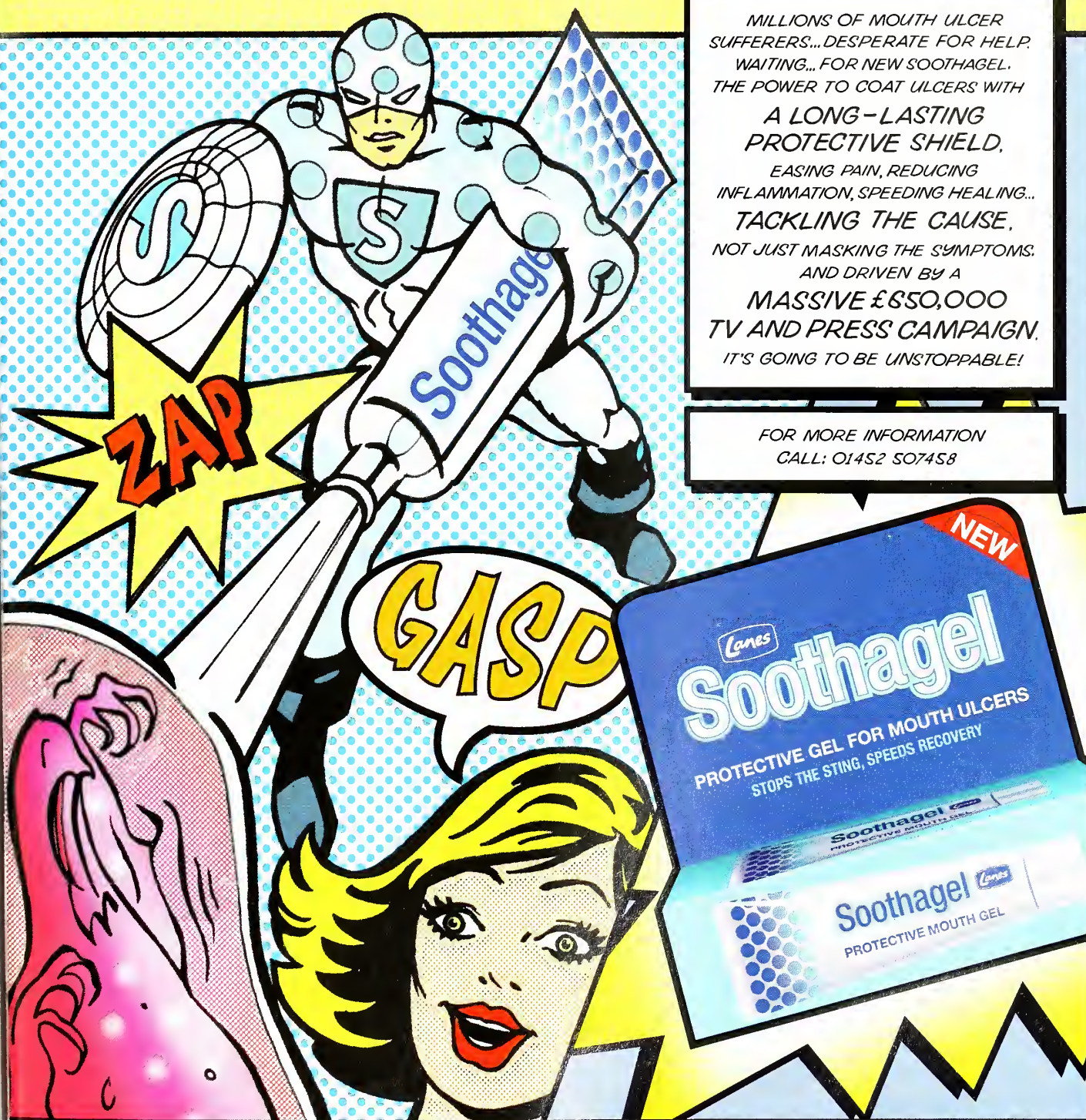


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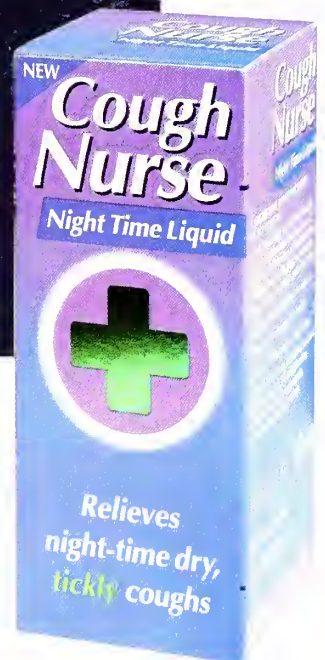


When the mucous lining of the throat becomes inflamed and sensitive, it triggers repeated bouts of dry tickly coughs, which can seriously disturb a good nights rest. If for any reason we have inadequate restful sleep we wake up tired and unable to cope the next day. Cough Nurse Night Time Liquid

Cough Nurse Night Time Liquid. **Presentation:** Clear, yellow-green coloured syrup containing diphenhydramine hydrochloride 50 mg, pholcodine 15 mg per 20 ml. **Uses:** Symptomatic relief of dry, tickly, unproductive coughs. **Dosage and administration.** *Adults and children 12 years and over:* 20 ml at bedtime. *Children under 12 years:* Not recommended. **Contraindications:** Hypersensitivity to ingredients. Avoid in pregnancy and lactation. **Precautions:** May cause drowsiness; if affected do not drive or operate machinery. Avoid alcoholic drink. Caution required.



Night, night.



specially designed to dampen down night time tickly coughs. And so aids restful sleep.
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Diphenhydramine Hydrochloride, Pholcodine

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anxiety or depression, irritability and nightmares. **Legal category:** P **Product licence number:** PL 00014/0230 **Product licence holder:** The Boots Company PLC, 1 Thane Road West,
Letchworth, SG6 3AA **Package quantity and RSP:** 150 ml £3.99. **Date of preparation:** September 2004 Cough Nurse is a trademark of the GlaxoSmithKline group of companies

Please e-mail your views to chemdrug@cmpinformation.com

Staffing issues hold pharmacy back

I totally agree with David Morgan (*C&D*, October 23, p16) and it sadly shows the state that community pharmacy has reached.

The major problem is that area managers and contractors (particularly multiples) have only one concern and that is the money coming in (and the budget going out). Brownie points are not awarded for efficiently run dispensaries and the minimum staff is always used. I personally believe that a lot of the younger members of the profession (younger than 30 years old) are becoming disillusioned with pharmacy as a career and cannot see a future in it despite the so-called new ideas which are coming in the future.

I have only been qualified for six years and have discovered that pharmacy is very slow moving. Most of my friends and myself required high grades at A level to obtain a place at university, but now I wonder why. The job that most pharmacists end up doing is not very fulfilling and monotonous as this is the role that the contractor/multiple wants them to do. Any forward thinking is not allowed as this may require additional staff or may not increase turnover at the tills or dispensary.

By making CPD mandatory does the Society really believe this will improve the image and professionalism of pharmacy? I very much doubt it. For pharmacists to become truly happy and professionally satisfied in their role we must get away from the dispensary but most young pharmacists are held back due to restraints of lack of staff and poorly trained staff.

How are we to take on extra roles which would be more satisfying and rewarding if the menial task of dispensing cannot be done by other members of staff due to lack of numbers and training? I believe this should be

enforced more by the Society and the number of staff and trained staff should be monitored along with the number of items dispensed. That is a certain number of trained dispensers to a certain number of prescription items.

In some of the examples received by *C&D* so far I would say some may even pose a risk to the general public, especially if two sets of eyes don't see the prescription; and the untidiness leads to more near misses. There is no point in introducing SOPs by the multiples if the dispensary is a danger on its own and the SOPs sit in a file only to be looked at once a year.

I think it would be a good idea to have a questionnaire for younger pharmacists to fill out anonymously so you can get a general consensus of the state that pharmacy has got itself into. I believe that pharmacy is not a very satisfying career but could be but for the contractors/multiples who will not let the profession move forward, largely due to lack of resources (staff) and also technology (some multiples will not invest in better computer/ordering systems).

Wishing for a better future for pharmacy.
*pharmacist,
Oxfordshire.*

Nobody is listening

I have been a full time locum for 25 years and can honestly say that David Morgan's article and the ensuing letters are all true but sadly just the tip of the iceberg (*C&D*, October 23, p16 et seq).

The multiples are ruled by stupidity and greed and as they expand community pharmacy is getting worse in every way. Nearly every pharmacist, dispenser and pharmacy assistant

Another pharmacist has a confession to make...

I know how *Nxayser* feels (*C&D*, October 30, p15). Having always worked at the sharp end of community pharmacy in various positions, I have never learned the language of bureaucracy, but now it appears I will have to in order to justify my existence as a pharmacist.

I will go to an educational evening run by the local branch and hopefully that will tell me all I need to know about this new system.

I watched the videos in the CPD pack but did not feel enlightened by them. What do I write about? How much? How relevant to a part-time pharmacist? Does being appointed secretary/treasurer/auditor to an organisation count? If I do a computer course at the local college is this CPD? Is it relevant to my current or future practice? Who knows? At least it will be something to write about. Does all the CPPE time I have spent over the years count towards CPD? Do I do CPD and not CPPE?

I have yet to find anyone in my area who can show me examples of CPD records, and this is a pilot area. If I am unfortunate enough to be one of the first to be selected to submit CPD records, will I be removed

from the Register before others have even been asked to submit theirs? What standards am I supposed to be working to?

Sorry, I've run out of questions. Maybe I'll receive some answers and more accurate guidance before January 1.

*John Derbyshire MRPharmS,
via e-mail.*

New contract is unfair to the smaller contractors

When PSNC started negotiating the new contract, it stated that no one would be disadvantaged. The distribution of the funding of the contract was given in full to PSNC with no Government interference.

So why are the small contractors with 2,000 or fewer prescriptions being discriminated against by withdrawing the annual establishment payment after three years? It was also stated by PSNC that the vote on the new contract by the members was unanimous. It was not.

There are some 'discrepancies' in the communication booklet. For example, it will be around 700 contractors affected and not 100 as stated in the booklet. If you read the small print you will discover that there will be yearly increases to the number of scripts, thus more and more contractors will become disadvantaged.

This has been done by the very people that we pay to negotiate on our behalf. Vote no.
*Mrs EE Hopkins MRPharmS,
Ealing, West London.*

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Journalist sparks internet POM investigation

Prescription Only Medicines were available from a London pharmacist via the internet without customers having to go to a doctor, the Royal Pharmaceutical Society's Statutory Committee heard last month.

In the first case of its kind to come before the Committee, ABC Drugstores Ltd of Portobello Road, Notting Hill and its superintendent pharmacist Julian Wyatt faced a series of allegations of misconduct for which they could be put out of business. The Committee adjourned the hearing to a date yet to be fixed when it would announce its decision, which could have long-term effects on the prescribing of drugs over the internet.

The case came to light when Oliver Harvey, a journalist on *The Sun*, managed to buy Viagra via the website Menscare UK. Later he obtained the slimming drug

Reductil without a prescription.

David Bradley, for the Society, said Menscare UK was selling the drugs for around three times their recommended price or more. Mr Harvey paid £120 for his tablets when the official price would have been £35.87.

When the complaint was made, RPSGB inspector Tim Snewin visited the Portobello Road premises – one of over 30 pharmacy businesses owned by ABC. At first he could not find any sign of Mr Harvey's bills on the pharmacy's prescription records, but then discovered a small room on the third floor of the property, which was a second pharmacy for sending out medicines ordered via Menscare UK.

It was found that prescriptions purporting to come from a 'Dr E' had been sent to the pharmacy but there had been no valid prescription at the time of supply.

"ABC was just a sub-contractor for somebody else and I got the impression they were trying to conceal the business. To get to the second room you had to climb the stairs and go through a warren of corridors," said Mr Snewin.

Mr Wyatt said in his defence that he had joined ABC Drugstores Ltd seven and a half years ago. In a hand-over session with his predecessor, Stuart Evans, he had asked questions about the legality of dispensing over the internet.

Mr Evans had assured him that everything was above board. He also contacted the GMC to check whether 'Dr E' was fully registered and with the NPA. There appeared to be no problems. "I now know that the advice was wrong," said Mr Wyatt. "I realise I have made mistakes. If I had realised at the time I would have resolved them or I would have stopped the service."

Reprieve for pharmacist 'under pressure'

An Oxfordshire pharmacist who was twice convicted for failing to keep proper drug and poisons registers has been allowed to continue in business.

In June this year at North Oxfordshire Magistrates Court Kaushik Patel of Banbury was fined £4,000 after pleading guilty to failing to comply with the provisions of the *Misuse of Drugs Act*.

Two years earlier, he had been fined £2,000 after admitting a similar charge.

Last month, Geoffrey Hudson told the Royal Pharmaceutical Society's Statutory Committee that the lack of proper records at Jessica's Pharmacy in Banbury, between October 2002 and December 2003, came to light when police drugs inspectors made a routine visit.

A check on the pharmacy

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computer revealed that over 1,750 entries, which should have been made in the CD Register, were missing.

Mr Patel told the Committee he had been under pressure at the time because he had to look after his autistic teenage son and work in the pharmacy at the same time. "I do not trivialise what happened in any way but I just let the book-keeping fall behind," he said.

The Society had issued Mr Patel with a warning after his first conviction and, while he realised how serious that was, the pressure had got on top of him.

Issuing a further reprimand, Committee chairman Lord Fraser of Carmyllie QC said: "In normal circumstances there would be little option but to order your removal from the Register.

"But there were exceptional circumstances with which we sympathise. You had an autistic child who was terrorising his mother but we are now satisfied that a new package of care has been organised for you."

The Committee had been impressed by a number of references submitted to them praising Mr Patel's service to the local community.

Husband and wife ordered to be struck off after action against UniChem

Two pharmacists who harassed and threatened UniChem board members "out of desperation" have been struck off the professional register.

Husband and wife Christopher and Lynda Chanin of Birkenhead, harassed board members and employees of UniChem after it took over their pharmacies to pay a £385,000 loan due to their financial difficulties.

Mr and Mrs Chanin, directors of Chanins Pharmacy Ltd, received a loan from UniChem in June 2000 but by April 2002, receivers were sent in to possess the pharmacies.

The 21 allegations, covering April 2002 to July 2003, involved threatening letters, phone calls and faxes to the homes and offices of UniChem board members.

The Chanins were accused of setting up a website to criticise board members and employees but this was taken down this February. They also claimed to have made a CD with threatening

material, which turned out to be blank.

The Committee had heard from Alison Foster, for the Society, how on July 18, 2002 the couple were put under a High Court injunction forbidding them to enter or occupy their two pharmacies in Bebbington, Wirral and Greenfields, Birkenhead. The injunction also stated they could not interfere with the receiver's possession of these premises.

In their defence Mr Chanin told the Committee: "We set up the website to try and talk to them. We were desperate to find out what would make them take notice of us." He claimed the company was using the suggestion of making a complaint to the Society as a bargaining tool. "I believe the complaint was made in order to stop us doing what we were doing. I think it was a negotiating tactic."

He also claimed the receivers had sold the pharmacies when they were not theirs to sell, as the

lease was still in the Chanin's names. Further, the receivers should have made enough to pay back the creditors in full but they were not paid any money, claimed Mr Chanin.

"The whole philosophy is to try and turn the business round, pay the creditors and leave something for the owners," he added.

Mr Chanin went on to claim that a meeting held with UniChem had been intentionally arranged by the company to coincide with its AGM, so the couple could not attend – they had believed it to be the following day.

But they received an email saying: "You needn't bother turning up tomorrow to the AGM because it's just been held." This was followed by two attempts to retract the message – as though the sender realised it would cause trouble.

Mr Chanin said he and his wife

Continued on page 26

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◀ Continued from page 25

were concerned that the directors of the company had not been aware of the situation – that the decisions were being made lower down the chain of command and not being passed on.

“We weren’t attempting to bully them; we were simply informing them of what was going on.”

Summing up the situation, Mr Chanin said: “It was like a steamroller, it’s not just a flash then it’s over, it keeps going again and again and again.”

After adjourning the hearing last month to allow time to consider the evidence, the Statutory Committee announced on October 20 its decision to strike both Mr and Mrs Chanin off the Register.

In his summing up, Statutory Committee chairman Lord Fraser of Carmyllie QC said that during the opening minutes of the first day of the hearing he had indicated to parties that many years ago, one of the Statutory Committee members, Mr Rucker, had been a non-executive director of UniChem Limited long before it was floated as a public company

and a very considerable time before it became within Alliance UniChem Plc.

Furthermore Mr Rucker knew nobody now working for UniChem. No objection was taken to him sitting on the Committee on that first day but on the second day it was stated that Mr Rucker had what was described as a “substantial” shareholding in UniChem. “In fact, he has 1,000 shares valued at about £5,000.

“In my view, that relatively small holding was not sufficient to disqualify him, but Mr Rucker intimated that if objection to his presence was renewed he would withdraw from hearing the case. This he did and he took no further part in the proceedings or in our deliberations.”

But Lord Fraser criticised UniChem: “While I am not critical of UniChem’s actings in appointing administrative receivers in April 2002, and I can understand why they have now reached a settlement with the Chanins, the terms of which are unknown to us, I must express my concern that having made a complaint to the Royal Pharmaceutical Society, after a

settlement was reached they sought to have the Royal Pharmaceutical Society drop the complaint. That is unacceptable. The Royal Pharmaceutical Society are the guardians of the Register, not UniChem, and it is for this Committee as part of the machinery of self-regulation under statute to determine whether individuals should be on the Register or not.

“I am not impressed that UniChem should have threatened that their witnesses, directors or employees, would refuse to give evidence before the Statutory Committee. That was irresponsible and unworthy of a major wholesale pharmacy company such as UniChem.

“In the event, there were witnesses from UniChem and I was unable to detect in their evidence any withholding of material which properly ought to have been put before the Committee.

“Nevertheless, this appeared to have been threatened at one time and UniChem should have recognised, as Mr Hudson correctly put it in a letter to the Chanins dated 2 April 2004, and I quote: ‘Whatever may have been

agreed between yourselves and UniChem, it is not determinative of whether or not the inquiry should proceed.’ ... Even if the Chanins did not understand this, UniChem certainly should have.”

Lord Fraser said that it was not disputed that items were sent by the Chanins but it was disputed that the examples given were offensive and/or threatening. “In our view, not only are all the examples threatening and offensive, but they were intended to be.”

Referring to a Privy Council hearing into the behaviour of a veterinary surgeon, Lord Fraser said that such the Privy Council’s view on professional standards of behaviour should equally apply to pharmacists.

“Mr and Mrs Chanin have singularly failed to conduct themselves in accordance with such standards and it is worthy of comment that even to the end of the hearing there appeared to be no insight or understanding of the extent of their departure from the professional standards required of pharmacists.”

The Chanins have three months in which to appeal.



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In the second of three articles on cytochromes P450, Professor Danny Burke explains how these enzymes feature in drug interactions and adverse effects

CYP in drug interactions

This article is the second of three designed as a simple introduction or refresher on why CYP enzymes feature so frequently in medicines datasheets warnings about drug interactions and adverse drug effects.

The first article described the salient features of CYPs (*C&D*, October 2, p23). This one examines drug interactions and adverse drug effects resulting from the inhibition and induction of CYPs. The final article will consider CYP genetic polymorphism, some CYP-dependent diseases and the effects of grapefruit juice and herbals on CYPs; it will also include a table of selected drug substrates, inhibitors and inducers of CYPs. Only the main human drug-metabolising CYPs are considered here.

Introduction

The actions and excretion of 90 per cent of drugs in humans are affected by their metabolism by a collection of nine CYP enzymes. Drug interactions and adverse effects can occur when the normal metabolism of drugs is altered, either as a result of the inhibition or induction of CYPs by other drugs, or as a result of innate genetic deficiencies in CYPs.

Important examples of adverse drug interactions resulting from either inhibition or induction of CYPs include: cardiac arrhythmia (torsade de pointes) with terfenadine (consequently withdrawn); muscle degeneration (rhabdomyolysis) with statins; hypotension with calcium channel blockers; excessive sedation or respiratory depression with benzodiazepines; and failure of immunosuppression by ciclosporin.

Inhibition and genetic deficiencies result in decreased drug metabolism, whereas induction results in increased drug metabolism. Fluvoxamine inhibits the CYP1A2 metabolism of theophylline, thereby elevating theophylline blood concentration potentially to the point of toxicity.

Conversely, phenytoin induces the CYP3A4 metabolism of ciclosporin, decreasing the blood level of ciclosporin potentially to the point that it no longer provides effective immunosuppression.

Selectivity

A drug is rarely metabolised by all nine CYP enzymes. More usually it will be selectively metabolised by just one of the CYPs, although often with additional, lesser contributions from two or three of the other CYPs (*as detailed in Part 1*). Drugs are also highly selective as to which CYPs they inhibit or induce. For example, ketoconazole inhibits CYP3A4 but not CYP2D6, whereas quinidine inhibits CYP2D6 but not CYP3A4. Most drugs inhibit or induce only one or two CYPs, but some are less selective – for example, cimetidine and rifampicin inhibit and induce, respectively, six CYPs (albeit to differing extents).

Inhibitors outnumber inducers by about 3.5-fold and only a mere handful of drugs are both an inhibitor and an inducer. In order to understand and predict CYP-dependent drug interactions one needs to know not just which CYPs a drug inhibits or induces, but also which CYPs metabolise the potentially interacting drugs. This is because a drug that inhibits or induces a particular CYP will affect only those other drugs that are metabolised by that same CYP. Likewise, a genetic deficiency in a particular CYP will affect directly only those drugs that are metabolised by that same CYP. Fortunately, extensive lists of the necessary information are readily available on the internet (*see bibliography*).

Nuances

The clinical seriousness of CYP-dependent drug interactions can be exacerbated by other pharmacological factors. Inhibition of the CYP2D6 metabolism of thioridazine can cause the potentially fatal cardiac



Tom Oldham (c) Addiction 2004

Drug users who inject recreational drugs run the risk of HIV infection and drug interactions because many drugs are metabolised by CYPs inhibited or induced by anti-HIV medications

arrhythmia, QT-prolongation. The possibility of this arrhythmia is increased if the patient is also taking medication that decreases blood potassium.

The likelihood of CYP-dependent drug interactions can also be increased by non-pharmaceutical factors. Thus, the risk of not only HIV infection but also drug interactions are both greater in those who self-inject

recreational drugs, because many of these compounds are metabolised by CYPs that are inhibited or induced by anti-HIV drugs.

The consequences of CYP inhibition can be financial as well as clinical. Over recent years terfenadine, astemizole and cisapride were withdrawn largely

Continued on page 30 ➤

because of their cardiac toxicity when co-administered with drugs that inhibit CYP3A4. Mibefradil was withdrawn because its potent inhibition of CYP3A4 resulted in toxicity from statins and cardiovascular drugs metabolised by this CYP.

Inhibition

Specificity: a result of the fit between a drug's chemical structure and the configuration of the channels, pockets and amino acids in CYPs, which determines which drugs can access and bind to which CYPs. This specificity controls not just access for metabolism by CYP but also access for inhibition of CYP. Consequently a drug is most likely to inhibit those CYPs by which it is metabolised. For example, ritonavir is metabolised mainly by CYP3A4 but also, to a lesser extent, by CYP2D6. Accordingly, although ritonavir can inhibit seven different CYPs in total, CYP3A4 and CYP2D6 are the most strongly and second-most strongly inhibited forms respectively.

In the prevalent mechanism of inhibition, the inhibitory drug and the drug whose metabolism will be inhibited compete with each other for access to the same channels, pockets and amino acids in the same CYP molecule. As ritonavir shows, however, drugs can inhibit CYPs that do not metabolise them. For example, quinidine specifically inhibits CYP2D6 but is metabolised by CYP3A4. Cimetidine is, unusually, a non-specific inhibitor of CYPs in general.

Therapeutic choice

It is often the case that different drugs in the same pharmacological class selectively inhibit different CYPs. This sometimes enables an alternative drug to be selected in order to avoid the inhibition of a particular CYP. For example, the SSRIs fluvoxamine and fluoxetine selectively inhibit CYP1A2 and CYP2D6 respectively (although both also inhibit CYP3A4). As a result, while both drugs clinically inhibit the metabolism of clozapine (which is mediated by CYP1A2 and CYP2D6), only fluvoxamine inhibits the metabolism of olanzapine (mediated mainly by CYP1A2 alone).

Among antifungals, fluconazole has weaker than ketoconazole as an inhibitor of CYP3A4 but is stronger than ketoconazole as an inhibitor of CYP2C9. And

comparing anti-HIV NNRTIs (non-nucleoside reverse transcriptase inhibitors), delavirdine inhibits CYP3A4 whereas nevirapine induces it.

Clinical significance

Drug interactions involving inhibition are most likely to be clinically significant if the CYP affected is responsible for the main mechanism of deactivation of the drug. For example, warfarin is inactivated mainly by CYP2C9; amiodarone inhibits CYP2C9 and so can potentiate warfarin anticoagulation.

Conversely, CYP2C9 is responsible for only a minor proportion of the metabolism of sildenafil and so sildenafil plasma levels are generally not increased by drugs that selectively inhibit this particular CYP.

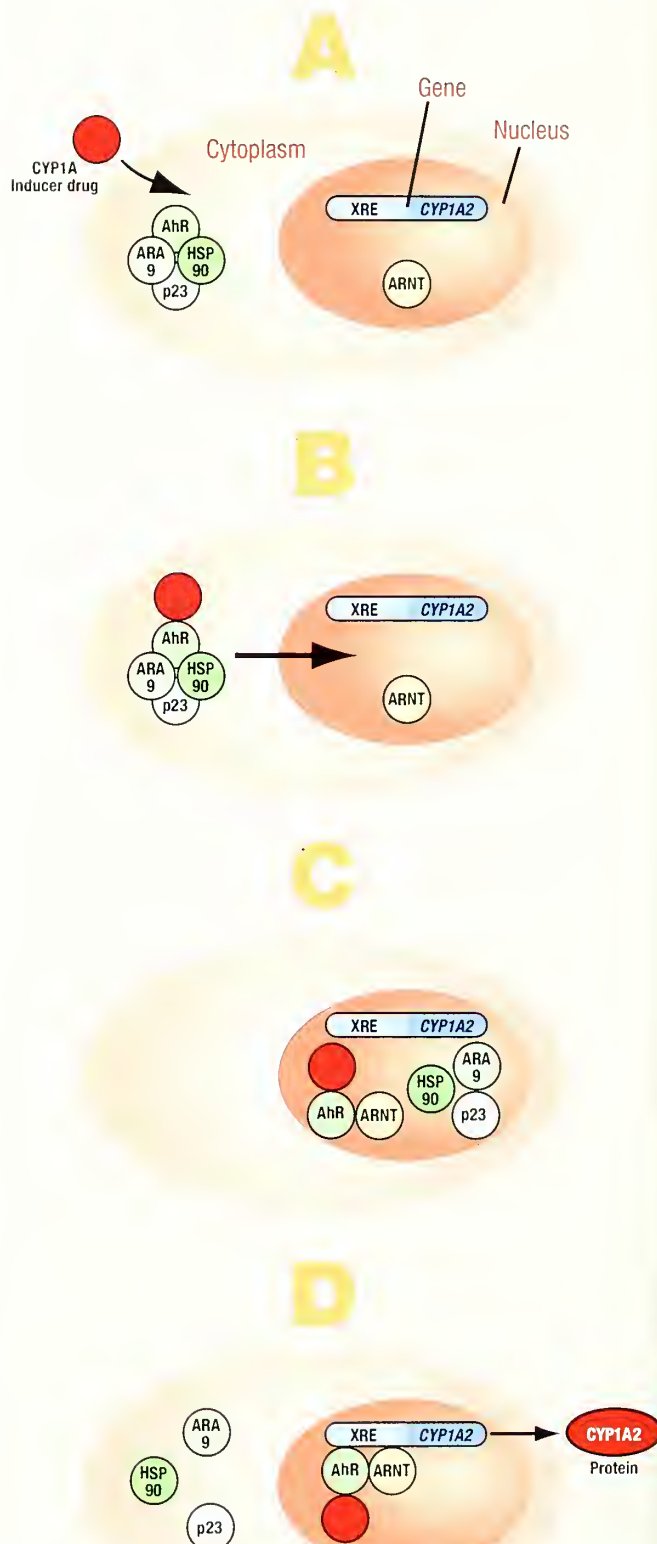
Sildenafil is, however, eliminated mainly through hepatic metabolism by CYP3A4 so datasheds specifically warn that concomitant use with inhibitors of CYP3A4 (for example, ketoconazole, ritonavir, grapefruit juice, cyclosporine or erythromycin) might result in increased plasma levels, needing a compensatory reduction in dose.

Drugs that are metabolised by several forms of CYP, such as fluvastatin (mainly by CYP2C9 but also by CYP2D6, CYP2C8 and CYP3A4), are less likely to be susceptible to drug interactions arising from CYP inhibition. This is because it is improbable that all the CYPs involved in the metabolism will all be inhibited by any other single drug at the same time.

Some experts recommend that if co-administration with a drug known to be a CYP inhibitor is unavoidable, then if possible the other drug should be one that is not metabolised by the inhibitable CYP. For example, in choosing a statin for co-administration with drugs that inhibit CYP3A4, the preference might be for pravastatin because it is not metabolised by CYPs, or for fluvastatin because it is metabolised mainly by CYP2C9, rather than for other statins that are metabolised by CYP3A4 and which might give rise to muscle pain or weakness in the presence of CYP3A4 inhibitors.

Likewise it has been suggested that, because most anti-HIV protease inhibitors are metabolised by CYP3A4, they should not be given concurrently with the strongest CYP3A4

Figure 1. Sequence of events in the induction of CYP1A2



This diagrammatic representation starts at (A) where the inducer drug enters the cell cytoplasm, where it (B) binds to the Ah receptor protein (AhR), which is itself complexed with other proteins (HSP90, p23 and ARA9). As a result, (C) the entire receptor complex with inducer drug translocates to the cell nucleus. HSP90, p23 and ARA9 then dissociate and the drug-AhR complex binds with the ARNT protein. (D) The AhR-ARNT-drug complex binds to the XRE regulatory sequence of the CYP1A2 gene, resulting in increased synthesis of CYP1A2 protein

Continued on page 32 ►

Future



PLUS

a. FFTT
b. TTTT
c. FFTT
d. FTTF
e. FTTT

The therapeutic drug monitoring of drugs with a narrow therapeutic range (narrow margin between therapeutic and toxic dose) may be used as part of routine monitoring, or to inform aspects of patient care such as suspected toxicity or inadequate clinical response despite high dosage.

MEDICINES USE REVIEW

Therapeutic 10 Drug Monitoring

BY PROFESSOR CLARE MACKIE

Linear and non-linear pharmacokinetics

The general aim is to describe the concentration v time profile of a drug in plasma in order to inform optimal dosage regimens, with the assumption that concentration and effect (therapeutic and/or toxic) are related. Most drugs exhibit linear (first order) kinetics, meaning that the plasma concentration is proportional to the dose. In general if the dose is doubled, then the plasma concentration is doubled.

Certain drugs are associated with saturation metabolism (within the normal therapeutic range), so that above certain concentrations their elimination becomes non-linear (zero order) and proceeds at a fixed rate, regardless of the plasma concentrations. In this zero order phase, a small increase in dose can lead to a large increase in plasma concentration. Drugs which exhibit non-linear kinetics within the normal target range include phenytoin, aspirin and salicylates.

At steady state an equilibrium is established between input and output of drug. For most drugs TDM is only meaningful when the drug is at steady state, therefore following initiation of treatment or alteration of dose regimen a time period should be allowed to elapse prior to sampling. This is usually a time period equivalent to five half lives.

The purpose of drug monitoring (TDM)

A TDM service provides advice on drugs with a narrow therapeutic range (narrow margin between the therapeutic and toxic dose) and may be used as part of routine monitoring, or to inform aspects of patient management. **It is important to treat the patient and not the level.** If a patient is stable clinically, and the concentration of drug is found to be below the therapeutic range, the dose would not usually be changed unless indicated clinically.

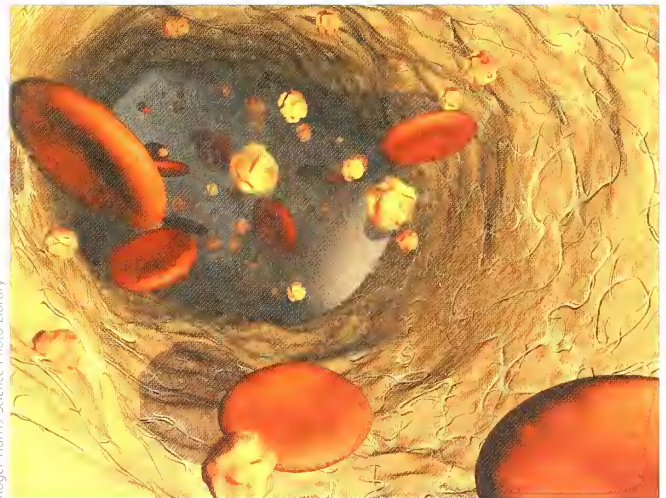
Data required on all TDM request forms should include:

- Reason for monitoring
- Dose and frequency
- Duration of therapy
- Age/weight/sex/height
- Sample time and time of last dose
- Other drug therapy

Interpretation of results

This is a specialist function, usually undertaken by pharmacists and biochemists, that provides comments on the results and may suggest appropriate changes to dosage regimens or advice on re-analysis. A small number of community pharmacists are already involved in providing therapeutic drug monitoring services. This is a specialist service which requires training beyond the scope of this Module (see *Recommended reading*). However, the 'non specialist' pharmacist should have an understanding of the basic principles which contribute to patient care without the need for complex calculations.

In the primary care situation only a few drugs require routine monitoring of plasma concentrations. Examples include digoxin, lithium, phenytoin and theophylline (see individual drug profiles below). In addition, infrequent monitoring in primary care may be helpful in certain clinical situations such as suspected toxicity, suspected non-compliance, poor response despite high dose, and potential drug interactions.



Roger Harris Science Photo Library

Individual drug profiles

1. Digoxin

Target range: 1.0-2.6 nmol/l (at 6-24 hours post dose)

Loading dose and concentration measurements are not as important in heart failure patients.

Time to steady-state: Seven days with normal renal function but longer if renal function is poor. A loading dose may be given to shorten the time to steady state if indicated clinically.

Timing of sample: 6-24 hours post dose (as it takes six hours for the drug to be distributed into cardiac muscle, a measurement taken before six hours can be misinterpreted and provide a misleading result).

Symptoms of toxicity: Nausea, vomiting, confusion, visual disturbances, cardiac toxicity, eg bradycardia.

Dose alteration: This drug exerts its action in cardiac muscle by inhibiting the cardiac Na^+/K^+ pump (Na^+/K^+ -ATPase). Hypokalaemia predisposes to digoxin toxicity and potassium levels should be checked if this is suspected. As digoxin exhibits linear kinetics, the dose may be altered proportional to plasma concentration if indicated clinically.

2. Lithium

Bioavailability: Preparations vary widely in bioavailability therefore prescribe by brand name only. Lithium carbonate 200mg is equivalent to lithium citrate 509mg.

Changing preparation requires the same precautions as initiation of treatment. The brand name and formulation (eg liquid, tablets) should be stated on the TDM request form.

Target range: 0.4-1.1 mmol/l (lower end of range for maintenance therapy and elderly patients).

Time to steady-state: 4-7 days.

Timing of sample: 12 hours after the last dose.

Drug interaction: Patients should maintain adequate fluid intake and avoid dietary changes which may increase or decrease sodium intake. Lithium toxicity is made worse by sodium excretion, therefore concurrent use of diuretics (particularly thiazides) is hazardous and should be avoided.

used (see Appendix 1 of BNF 7th ed) for other potentially hazardous drug interactions.

Symptoms of toxicity: Blurred vision, vertigo/dizziness, disturbance of appetite, vomiting, diarrhoea, muscle weakness, TTP, disturbance of gait, tremor, dysarthria, convulsion. In long-term use, lithium has been associated with thyroid disorder, and mild cognitive and memory impairment. Regular monitoring every 6–12 months of thyroid function is required for patients requiring long-term treatment.

Dose alteration: Lithium exhibits linear kinetics, so the dose may be altered proportional to plasma concentration if indicated clinically.

3. Phenytoin

Dose and form: Phenytoin sodium 100mg is equivalent to 90mg phenytoin base. Epanutin capsules and injection contain phenytoin sodium. Epanutin suspension and Intatabs contain phenytoin base. The brand name and formulation (eg tablets, suspension) must be stated on the TDM request form.

Target range: 40–80 micromol/l (10–20mg/l)

Time to steady state: 2–3 weeks

Timing of sample: Immediately before an oral dose

Drug interactions: Enzyme inhibitors increase the concentration of phenytoin, so a dose reduction may be necessary (see Module 9). Enzyme inducers decrease the concentration of phenytoin, so a dose increase may be necessary (see Module 9). It is important to remember to monitor the patient and reduce the dose of phenytoin gradually as the inducer is withdrawn.

Symptoms of toxicity: Nausea, vomiting, slurred speech, blurred vision.

Dose alteration: Phenytoin is 90% bound to serum albumin with the 10% free phenytoin able to exert its therapeutic effect. Reduced protein binding may occur in pregnancy and in renal and hepatic disease. Specialist advice should be sought

for such patients. Phenytoin exhibits non-linear kinetics (different from most drugs) and a small increase in dose can cause a large increase in concentration.

4. Theophylline

Dose and form: Modified release preparation – should be prescribed 4–12 times daily only. The brand name and formulation (eg capsules, tablets) must be stated on the TDM request form.

Target range: Adult: 5–10 mg/mmol (10–20 mg/l). Patients may be controlled at lower concentrations, and 28.5 mg/mmol (5–10 mg/l) has been suggested as an anti-inflammatory steroid-sparing range, but this would be determined by specialists.

Time to steady state: Usually about two days

Drugs that may prolong time to steady state: Severe congestive heart failure, Hepatic cirrhosis, Chronic obstructive pulmonary disease (COPD), Chronic alcohol intake.

Timing of sample: Immediately before an oral dose

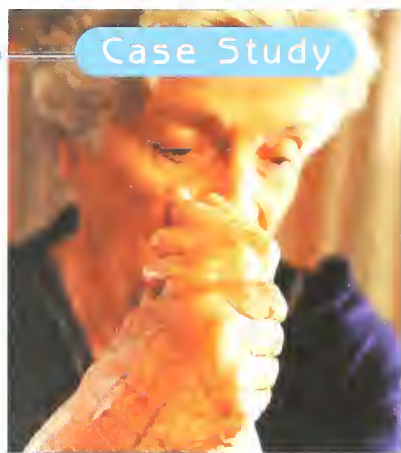
Drug interaction: Enzyme inhibitors increase the concentration of theophylline, so a dose reduction may be necessary. Enzyme inducers decrease the concentration of theophylline, so a dose increase may be necessary. The dose of theophylline will need to be adjusted if concomitant inducing/inhibiting therapy is changed. Monitor the patient closely and change therapy gradually.

Symptoms of toxicity: Vomiting, headache, tremor, tachycardia, hypotension and convulsions.

Smokers: Smoking can also cause enzyme induction which

means that in general smokers require higher doses of theophylline than non-smokers. Time to steady state may be reduced in smokers. State whether the patient is a smoker on the TDM request form.

Dose alteration: Theophylline exhibits linear kinetics (within the normal therapeutic range) so the dose may be altered proportional to plasma concentration if indicated clinically.



Case Study

Mrs S, a 73 year-old woman, presents in your pharmacy and requests an analgesic for 'migraine-like headaches'. Her symptoms include headache, disturbed vision, nausea and vomiting. You note that she has no previous history of migraine. Her neighbour, a 32 year-old migraine sufferer, has suggested that her symptoms may well be due to migraine.

Review of her patient medication records confirms that she has a history of osteoarthritis for which she takes paracetamol on a regular basis. You also note that she has been prescribed digoxin and warfarin recently to treat atrial

fibrillation. The dosage instructions for digoxin 125 micrograms were four daily for three days, then reduce to one daily. The dose of warfarin is adjusted at the anticoagulant clinic, which she attends on a weekly basis.

On further discussion, Mrs S tells you that she is taking four small white digoxin tablets every morning – she cannot recall the actual strength of the tablets and appears unaware of any instructions to reduce the dose to only one in the morning. Her last dose of digoxin was taken at 8am this morning and it is now 3.30pm.

Reflect on this case. What are your concerns?

Upon reflection...

In view of her history, it is likely that the symptoms reported are indicative of digoxin toxicity. Due to the relatively large volume of distribution of digoxin, loading doses are often given to shorten the time taken to achieve steady state and therefore to establish response and

regular daily dosing. In this case, Mrs S continued to take a high dose of digoxin for a prolonged period.

The symptoms reported included vomiting which may have led to potassium loss (hypokalaemia). This may have exacerbated digoxin toxicity, as

potassium and digoxin share the same binding sites on cardiac muscle.

● In this case, Mrs S should be urgently referred for clinical assessment including determination of plasma digoxin, and urea and electrolytes.

Self-Assessment: Questions

For each of the following questions indicate whether the statement is true (T) or false (F).

a. Therapeutic drug monitoring is commonly used commonly to assist in the routine monitoring of the following drugs:

- 1 Warfarin 2 Captopril
3 Digoxin 4 Carbamazepine

b. The following factors influence the dose requirements of digoxin:

- 1 Age 2 Cardiac disease
3 Hepatic disease 4 Renal disease

c. The following is true of lithium:

- 1 Lithium exhibits non-linear kinetics within the therapeutic range.
2 Concurrent use of diuretics may cause sub-therapeutic concentrations in a patient previously maintained within the therapeutic range.
3 Recommended sampling time is 12 hours after the last dose.

- 4 Symptoms of toxicity include blurred vision.

d. The following conditions may lead to misinterpretation of phenytoin concentrations:

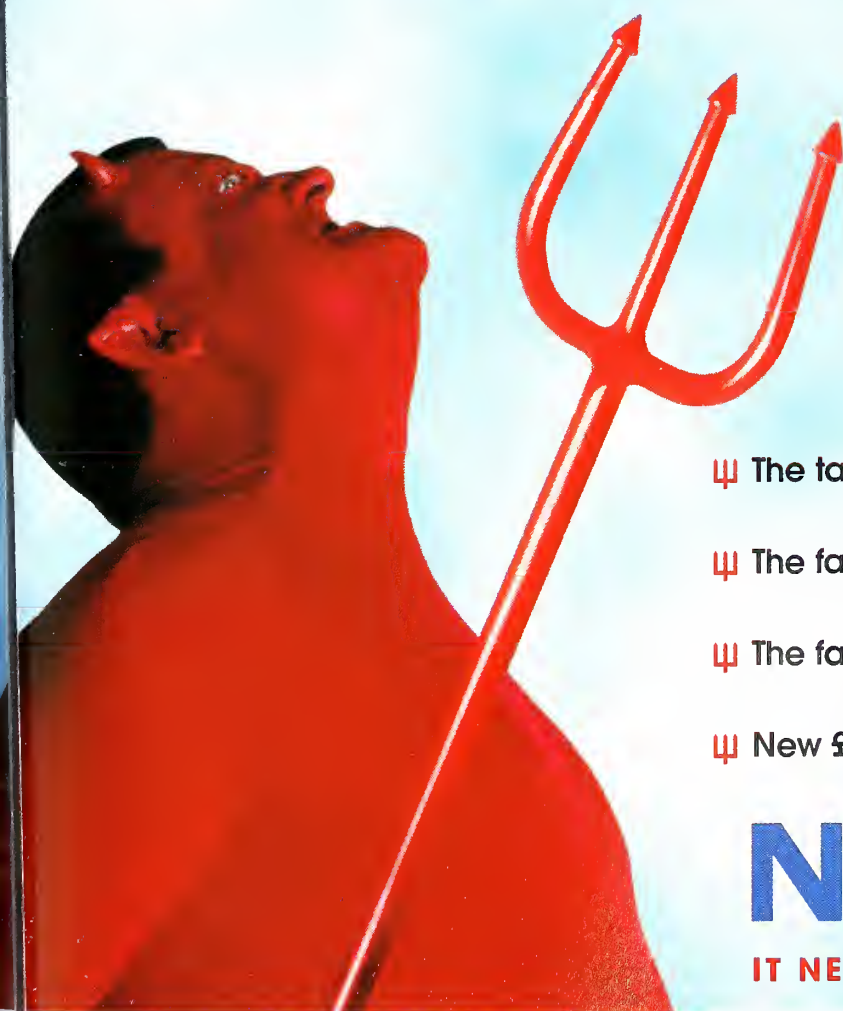
- 1 Cardiac disease 2 Renal disease
3 Pregnancy 4 Epilepsy

e. The following factors affect dose requirements of theophylline:

- 1 Renal function 2 Hepatic function
3 Age 4 Smoking status



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inhibitors (such as ketoconazole) or CYP3A4 inducers (such as rifampicin). Conversely, the co-administration of ritonavir with saquinavir exemplifies the idea of deliberately using a strong CYP inhibitor (ritonavir, of CYP3A4) to spare the metabolism and reduce the dose of a poorly bioavailable, more weakly inhibitory drug of the same class (saquinavir, metabolised by CYP3A4).

Time course

The most prevalent mechanism of inhibition, that is, simple competition for access to the same CYP between the inhibitory and inhibited drugs, onsets rapidly but is transient, wearing off once the blood concentration of the inhibitory drug drops (as a result of its metabolic detoxification and excretion from the body). The duration of this type of inhibition is determined by the drug's half-life; it typically lasts 24 hours after a single dose of a short half-life drug, for example, delavirdine (a CYP3A4 inhibitor – an antiretroviral not currently licensed in the UK), but can persist for 30 days with amiodarone (a CYP2C9 inhibitor) because of this drug's long half-life. A minority of drugs inhibit transiently through a different mechanism, by binding a nitrogen atom directly to the CYP iron, for example ketoconazole, while in a variation of this mechanism a metabolite of the drug binds more enduringly to the iron, for example, diltiazem.

Forecasting from *in vitro*

In trying to forecast the likelihood of CYP inhibition in living patients (*in vivo*), experimental findings in test tubes (*in vitro*) can be helpful. In a pair of drugs competing for metabolism by the same CYP, the inhibitor will be the one that binds more tightly to the CYP. Tightness of binding is measured *in vitro* by the "inhibitor constant", K_i . For most drugs, if the normal plasma concentration of the drug is more than 10-fold lower than its K_i , then the drug is unlikely to be a clinically significant inhibitor. Thus, as sildenafil is metabolised mainly by CYP3A4, it might also be expected to be a clinically significant inhibitor of CYP3A4. But evidence suggests otherwise, probably because sildenafil's normal plasma level in patients (1–2 micromolar) is much lower than its K_i value *in vitro* (80 micromolar). However, there are some drugs such as cimetidine

that inhibit certain CYPs *in vivo* but seem unable to inhibit the same CYPs *in vitro*.

Induction

Induction by drugs increases the amount of certain CYPs. This results in the induced CYPs increasing the rate of metabolism of other drugs. The metabolism of the inducing drug itself is also sometimes increased; this is "autoinduction" and is exemplified by carbamazepine. CYP induction is a less prevalent drug interaction than CYP inhibition.

Specificity and molecular

Induction is specific, in that particular drugs induce only particular forms of CYP, but the specificity is not related to the specificity for metabolism, inhibition or genetic polymorphism. For example, omeprazole induces CYP1A2, but is metabolised by and inhibits mainly CYP2C19. To induce CYPs a drug must interact with particular receptor proteins inside the cell, which activates the appropriate CYP gene and accelerates synthesis of CYP protein. The specificity is that of the receptor for the drug and for the CYP gene.

There are three main induction receptors: AHR for CYP1A2; CAR for CYP2B6 and CYP2C9; and PXR for CYP3A4. CYP2A6 is also inducible, for example by phenobarbital, but the mechanism is uncertain. CYP2E1 is inducible, notably by ethanol, but through a non-receptor mechanism. CYP2D6 is not inducible.

Clinical examples

The main danger of CYP induction is that, by accelerating the metabolism of drugs, induction can lead to drug blood levels being decreased to sub-therapeutic values. For example, cigarette smoking induces

Bibliography

The following Internet sites list CYPs that are inhibited or induced by individual drugs or metabolise them (with year of "publication"):

(1998)

http://www.dextroverse.org/Archives/P-450_Drug_Interactions.pdf

<http://www.aafp.org/aafp/980101ap/cupp.html>

(1999)

<http://pswi.org/communications/pharmacology/Cytochrome.pdf>

(2000)

<http://www.anaesthetist.com/physiol/basics/metabol/cyp/cyp.htm#alpha>

(2001)

<http://www.snowtigermed.com/cgi-local/viewarticle.pl?doc=991203132041>

<http://www.cc.nih.gov/phar/updates/DecUpdate01.pdf>

(2002)

<http://www.cpha.com/about/educ/ce/061502ce.pdf>

http://www.pharmj.com/pdf/hp/200206/hp_200206_cytochromes.pdf

(2003)

<http://www.edhayes.com/startp450.html>

(2004)

<http://medicine.iupui.edu/flockhart/>

CYP1A2, accelerating the metabolism of theophylline and olanzapine and sometimes necessitating a compensatory increase in their dose. Rifampicin induces the CYP2C9 metabolism of celecoxib and warfarin, thereby reducing their circulating concentration and potentially resulting in therapeutic failure. Conversely, the risk of paracetamol liver damage is increased in chronic alcoholics because ethanol induces CYP2E1 and its production of hepatotoxic metabolites from paracetamol.

CYP3A4 is the most often induced CYP and carbamazepine is its most documented inducer, for example, decreasing the levels of co-administered valproate by 60 per cent. The most potent clinical CYP3A4 inducer is rifampicin, for example, significantly increasing the metabolism and decreasing the effects of midazolam. Rifampicin induction of CYP3A4 also accelerates the metabolism and decreases the plasma levels of anti-HIV drugs, such as ritonavir and delavirdine, which can pose a problem in HIV patients who are co-infected with TB. Zidovudine

is metabolised by glucuronyl-transferase enzymes instead of CYPs, but its metabolism too is induced by rifampicin.

Time course

Whereas inhibition occurs rapidly it takes one or more days of continued drug administration to induce CYPs. Induction is dose-dependent. Drugs with longer elimination half-lives generally take longer to induce, because it takes longer for them to reach a sufficiently high steady state concentration in the blood. Contrast rifampicin, which has a half-life of around three hours and induces CYP3A4 within one to three days, with phenobarbital, which has a half-life of two to five days and takes about one week to induce the same CYP. Induction of CYP3A4 by carbamazepine begins within about five days of starting dosing but only reaches its full extent after a further 23 days of treatment.

In body cells CYPs are constantly being made and removed in a highly controlled way. Induction of CYP requires a continuing stimulus from the inducing drug. Consequently, after withdrawal of the drug the CYP level generally returns to normal within one to six weeks, as the CYP molecules themselves are replaced. After withdrawal of the inducing drug it is usually necessary to reduce the dose of any drug whose metabolism had been increased, so as to avoid excessive or toxic effects.

Professor Danny Burke is a former head of Leicester School of Pharmacy and, until recently, dean of health and science at Sunderland University.



Grapefruit is an inhibitor of CYP3A4 so should be used with caution with drugs metabolised by CYP3A4, such as sildenafil

CROOKES HEALTHCARE **PRODUCT INFORMATION NUROFEN FOR CHILDREN** Suspension containing ibuprofen 100mg/5ml. **Indications:** Prescription and OTC: For the fast and effective reduction of fever, including post immunisation pyrexia and the fast and effective relief of mild to moderate pain, such as sore throat, teething pain, toothache, earache, headache, minor aches and pains. **Dosage:** For pain and fever: The daily dosage of Nurofen For Children is 20-30 mg/kg bodyweight in divided doses. This can be achieved as follows: Infants 6 - 12 months: One 2.5 ml spoonful may be taken 3 to 4 times in 24 hours. Children 1 - 3 years: One 5 ml spoonful may be taken 3 times in 24 hours. Children 4 - 6 years: 7.5 ml (5ml + 2.5ml spoonful) may be taken 3 times in 24 hours. Children 7 - 9 years: Two 5 ml spoonfuls may be taken 3 times in 24 hours. Children 10 - 12 years: Three 5ml spoonfuls may be taken 3 times in 24 hours. For post immunisation pyrexia: One 5ml spoonful followed by one further 2.5ml spoonful 6 hours later if necessary. No more than two 5ml spoonfuls in 24 hours. If the fever is not reduced, consult your doctor. For oral administration, for short term use only. **Contraindications:** Hypersensitivity to any of the constituents. Patients with history of, or existing peptic ulceration. Patients with a history of asthma, rhinitis or urticaria associated with aspirin or other non-steroidal anti-inflammatory drugs. **Precautions and Warnings:**

If symptoms persist for more than 3 days, consult your doctor. Do not exceed the stated dose. Caution is required in patients with renal, cardiac or hepatic impairment. Asthma sufferers, anyone allergic to aspirin, receiving any other regular treatment and pregnant women should consult their doctor before taking Nurofen For Children Sugar Free. Nurofen For Children is not suitable for patients who have a stomach ulcer or other stomach disorder. Not recommended for children under 6 months unless advised by a doctor. **Side effects:** Hypersensitivity reactions have been reported following treatment with ibuprofen. These may consist of (a) non-specific allergic reaction and anaphylaxis, (b) respiratory tract reactivity comprising of asthma, aggravated asthma, bronchospasm or dyspnoea, or (c) assorted skin disorders, including rashes of various types, pruritis, urticaria, purpura, angiodema and, more rarely, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Side effects are rare but may include abdominal pain, nausea, dyspepsia and gastrointestinal bleeding and peptic ulceration. Also very rarely thrombocytopenia have been reported. Bronchospasm may be precipitated in patients with a history of aspirin sensitive asthma. **Product Licence Number:** PL 00327/0085 **Licence Holder:** Crookes Healthcare Limited NG2 3AA **Legal Category:** P **MRRP Price:** 100ml, £3.59 150ml, £4.72 **Date:** May 2004 **Code:** NFN649B



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Researchers question the use of atenolol

Beta-blocker atenolol may not reduce the risk of a heart attack or cardiovascular-related death, claim researchers from Sweden.

Researchers carried out a review of existing studies using atenolol and found that it was not significantly different from placebo in reducing the risk of death from all causes, cardiovascular causes or heart

attack. However, a reduction in the incidence of stroke was seen when atenolol was compared to placebo, say the researchers.

When compared to other antihypertensives, atenolol slightly increased the risk of cardiovascular death and stroke.

The researchers claim their results "cast doubt on atenolol as a

suitable first-line drug for hypertensive patients".

In addition, the results call into question the drug's suitability as a reference drug in hypertension trials, they say.

In 2003, over 16 million prescriptions for atenolol were dispensed in England.

For more information:

The Lancet 2004; 364: 1684-9



Take it easy on vitamin E, research has suggested

High vitamin E doses link with death

Large doses of vitamin E are associated with an increased overall risk of death, according to researchers in the USA.

Doses exceeding 400IU (international units) per day were linked to a higher risk of death in nine of the 11 trials analysed. Patients enrolled in the trials were mostly over 60 years old, though, so the authors warn the results may not translate directly to younger, healthy adults. Links with low doses of vitamin E and death were unclear.

The researchers say that more evidence is needed to determine the effects of low doses of vitamin E and the benefits of combining it with other antioxidants.

The research was presented at the American Heart Association conference in New Orleans last week.

Weight hits men where it hurts: their wallets

There's new evidence that could help men decide to lose the extra weight – overweight and obese men spend more on prescription medications than svelte men.

An American study found that middle-aged men who were of normal weight spent on average \$22.84 (approximately £12) per month at the pharmacy. In contrast, men who were overweight spent on average \$39.27 (ca £21) per month, but obese men spent \$80.31 (ca £43) per month.

The study also found that all main coronary heart disease risk factors, except smoking, increased as weight went up. More low back pain, GORD, erectile dysfunction, depression, sleep



Losing weight could have financial benefits as well as health gains

apnoea, hypertension and high cholesterol were seen as men's weight increased.

Peter Baker, Men's Health Forum director, said: "What this study shows is that, although men in the UK won't be liable for the same prescription costs as in the USA, there is an increased cost to the NHS as it is clearly going to mirror the USA. It is an incentive for the NHS to work with men to tackle their weight problems. The Men's Health Forum wants to work with the Department of Health and the NHS to develop a weight management programme for men."

The researchers presented their findings at the American Heart Association conference last week.

Amlodipine helps non-hypertensives with CAD

Amlodipine slows atherosclerosis and reduces the risk of cardiovascular events in individuals with coronary artery disease and normal blood pressure, claim researchers from the USA.

The Pfizer-funded two-year study compared calcium-channel blocker amlodipine 10mg, ACE inhibitor enalapril 20mg and

placebo in 1,991 patients with coronary artery disease (CAD) but without hypertension.

Patients who received amlodipine averaged a 5/3mmHg reduction (a 31 per cent relative reduction compared to placebo) from an average starting blood pressure of 129/78mmHg.

Enalapril patients averaged a statistically non-significant

5/2mmHg reduction in blood pressure (15.3 per cent relative reduction compared to placebo).

For every 16 patients who received amlodipine, on average one adverse cardiovascular event would be avoided; whereas for every 20 patients treated with enalapril, one CV event would be prevented, claim the researchers.

The results call into question

the appropriateness of current guidelines for antihypertensive use in coronary artery disease patients with "normal" blood pressure, say the authors. "These results suggest that the optimal blood pressure range for patients with CAD may be lower than indicated by current guidelines."

For more information:

JAMA 2004; 292: 2217-26



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TIXYLIX® CHESTY COUGH. Presentation: Sugar-free linctus containing 50 mg Guaifenesin in 5 ml. Indications: Relief of chesty coughs, hoarseness, and sore throat. Helps loosen mucus to make coughing easier. Dosage and administration: The following doses are given 4 hourly: Children 1 - 2 years 2.5 ml, children 3 - 5 years 5 ml, children 6 - 10 years 5 to 10 ml. Contraindications: Should not be used with a cough suppressant. Legal Category: GSL. Recommended Retail Price: £3.05. Product Licence Number: PL 0030/0082. Product Licence Holder: Novartis Consumer Health, Welwyn Garden City, Herts. AL9 1DA. Tel: 01438 744000. Fax: 01438 744001. Email: novartis@novartis.co.uk. Address: Novartis Consumer Health, Welwyn Garden City, Herts. AL9 1DA. Date of preparation: July 2004.

LCPs added to Enfamil

Mead Johnson Nutritionals has added long chain polyunsaturated fatty acids (LCPs) to its pre-thickened infant formula for infant reflux.

Enfamil AR now contains Lipil which is a blend of docosahexaenoic acid (DHA) and arachidonic acid (AA).

Clinical trials show that babies fed these LCPs achieve similar

visual acuity to breast-fed babies and demonstrate increased mental development at 18 months compared with babies fed with unsupplemented formula.

Enfamil AR is formulated with a rich starch thickener to reduce regurgitation and other gastro-oesophageal reflux related symptoms such as choking, gagging and coughing.

● Paediatric reflux is a common problem affecting up to 50 per cent of infants which usually resolves spontaneously by 6-12 months.

Price: £3.60

Pack size: 400g

Pip code: 225-5271

Mead Johnson

Nutritionals

Tel: 020 8754 3764



Wider appeal for herbal cough balsam

Allens is widening the distribution for its herbal cough and cold balsam into pharmacies around the UK.

Allens Pine & Honey Balsam is a long established, small northern brand from a family-owned company.

The natural product has a

formula dating back to the 1900s and is targeted at the 55-64 age group.

It will also be available in Waitrose stores from this month.

Price: 2.65

Pack size: 150ml (packed in cases of six)

Pip code: 094-7481

Allens & Co

Tel: 01484 519251

Scriptlines

Enlive Plus



The company has asked for short dated stock to be accepted on a sale or return basis.

For more information:

Aventis Customer Services

Tel: 0870 5133347

3M keeps Alu-Caps

3M Health Care has announced it will continue to manufacture and supply Alu-Cap capsules (aluminium hydroxide) to the UK market.

The company announced in February this year it intended to cease manufacture and supply of the product, but was working with the Department of Health to ensure a continued supply for patients. 3M has said it will continue to supply Alu-Cap capsules in "response to concerns raised regarding the availability of suitable alternative aluminium hydroxide preparations".

Wholesalers queries regarding stock availability and orders should be made to Keith Stacy, tel: 01509 613082.

For more information:

3M Health Care Medical Information
Tel: 01509 613265

Short-dated Orelox Paed

Aventis has announced the only available stock for Orelox Paediatric 100ml (cefepodoxime granules for suspension) has a shelf life of less than six months. The company says it cannot supply stock with a normal shelf life on it and the current short-dated product can be accepted on a sale or return basis.

For more information:

Aventis Customer Services
Tel: 0870 5133347

Benylin 4Flu Monitor

Brought to you by Benylin®

Nov 13

Benylin

KEY FACTS

● Manchester remains on Pre-Alert, whilst all other cities shown, except Birmingham and Glasgow, remain on Advisory status

● Over 3.5 million people in the UK (6.5% of the population) are currently suffering from a respiratory illness

● Coughing and sore throats are the most prevalent symptoms observed with both nasal congestion and runny nose also being widespread

● Cities on Normal
● Cities on Advisory
● Cities on Pre-Alert
● Cities on Alert

Glasgow
Newcastle
Leeds
Manchester
Birmingham
Norwich
Bristol
London

Benylin 4Flu Liquid

To relieve...
fever
congestion
body pains
cough

...the 4 main symptoms of flu

The all-in-one to relieve the 4 main symptoms of flu: fever, body aches and pains, nasal congestion and coughing – nothing is more effective without prescription

Visit www.coughandcoldadvice.com for more information

Source: SDI

As of November, Enlive from Abbott Nutrition will no longer be available and will be replaced with Enlive Plus.

Pharmacists who receive a prescription for Enlive should contact the relevant GP to advise that the prescription needs updating to Enlive Plus. Enlive Plus contains 10 per cent more energy and protein than Enlive, but is available in the same eight flavours.

For more information:

See Price List
Abbott Nutritional Services
Tel: 0800 252882

Diovan

Novartis Pharmaceuticals has announced that Diovan (valsartan) has been licensed to treat post-heart attack patients with evidence of left ventricular failure.

The company says valsartan is the only angiotensin receptor blocker to be licensed for this indication.

For more information:

Novartis
Tel: 01276 692255

Claforan

Aventis has announced the only available stock of Claforan 2g (cefotaxime) has a shelf life of less than six months.

Who knows

NOVARTIS

a fast way to break the congestion barrier?



Otrivine knows

You've always known Otrivine but did you know that it was the first topical nasal congestion treatment to contain xylometazoline?

Still unbeaten – it starts working in minutes and lasts for up to ten hours.

NO-ONE KNOWS NOSES LIKE

Otrivine®



Contains Xylometazoline Hydrochloride

OTRIVINE® ADULT NASAL SPRAY. Presentation: Nasal spray containing Xylometazoline Hydrochloride 0.1% w/v. **Indications:** Symptomatic relief of nasal congestion, rhinitis and allergic rhinitis (including hay fever), sinusitis. **Dosage and Administration: Adults and elderly:** Spray and One application in each nostril 2 or 3 times daily. **Contra-indications:** Sensitivity to ingredients. Trans-sphenoidal hypophysectomy or surgery exposing the dura mater. **Precautions:** Do not exceed the recommended dose or use for more than 7 consecutive days. Use with caution in patients showing a strong reaction to sympathomimetic agents, or with heart or circulatory disease. Advisable not to use in pregnancy. **Expiry:** Should be used by the person only to prevent cross-infection. Do not use the bottle for more than 28 days after opening. **Side Effects:** Occasional burning in nose and throat. Local irritation or dryness of nasal mucosa, nausea, headache. Systemic cardiovascular effects have been reported. **Legal Category:** GSL. **Product Licence Nos, Trade Price and Suggested Retail Price:** Otrivine Adult Nasal Spray: PL 0030/0116 10ml £1.91, £2.99. **PL Holder:** Novartis Consumer Health, Wimblehurst Road, Horsham, West Sussex, RH12 5AB. **Date of preparation:** September 2004.

Elegance at your fingertips

Original Additions is launching an Elegant Touch treatment range comprising eight products to improve the condition of the nails.

Nail Armour has a ceramic and acrylic formula to provide a nail hardening treatment with a smooth, silky finish.

Diamond Shield, which contains calcium and protein, is a hardener to prevent nail brittleness and splitting.

Quick Slick is a fast drying high gloss top coat to extend the wear of nail polish.

Triple Agent is a 3-in-1 all purpose treatment designed to act as a strengthener,



base coat and top coat.

Extreme Strength contains calcium, vitamin E and soya to

improve the condition and strength of weak, thin and brittle nails.

Nail Smoothie, which contains calcium and acrylic, fills and evens the surface as well as strengthening the nail.

Rapid Growth is a growth product that combines sea kelp with oyster shell particles to harden the nail.

Pro Cuticle Remover is a salon formula gel to remove overgrown cuticles and moisturise.

Price: £4.95 for all products except Nail

Armour and Diamond Shield (£5.95).

Original Additions
Tel: 020 8573 9907



TV boost for Accu-Chek

Roche Diagnostics is investing £750,000 in a TV campaign for its Accu-Chek Compact blood glucose testing system.

On air for four weeks from November 14, the advertising is targeted at type 1 diabetics.

The commercial shows a man walking his dog and throwing a frisby. In the time it takes the dog to fetch the frisby, the man has checked his blood glucose levels using the Accu-Chek Compact meter.

For more information:
Roche Diagnostics Ltd
Tel: 01273 480444

Eco-friendly nappies for Jackel

Jackel International is expanding its baby care line-up with the acquisition of CottonBottoms – a reusable nappy company.

The eco-friendly CottonBottoms range includes washable cotton nappies in Premature, Newborn, Newborn Super Absorbent, Small, Medium, Large and Large Booster Nappy.

CottonBottoms has won a number of environmental and consumer awards for its products and also runs the CottonBottoms nappy laundering business

as a franchise operation.

The range is currently sold in Boots, John Lewis, Woolworths Big W stores, Co-op Stores and independent nursery shops.

Jackel's baby care portfolio already includes the Tommee Tippee baby accessories brand, Steri-Bottle disposable bottle and the Nappy Wrapper disposable nappy system. The company says it is too early to announce its plans for CottonBottoms but the acquisition could widen distribution of the nappies into

pharmacies in the future.

As part of a drive to reduce landfill waste, the Government is investing £2.6 million in a 'Real nappies, real choice' campaign designed to convert parents to using washable nappies. The programme incorporates local council cash back schemes to parents who use washable nappies.

Price: from £10.00 for a trial pack to £299 for a Birth to Potty pack.

CottonBottoms
Tel: 08707 778898

Blotters seal up nicks and cuts

Alltracel Pharma is launching first aid strips for minor cuts and nicks into its Seal-on range of products.

Seal-on Blotters are impregnated thin film strips designed to act on contact with blood and stop bleeding quickly by forming a soft gel-like layer over the wound.

The product incorporates m.doc technology (micro dispersed

oxidised cellulose) to stop bleeding. The strip should be applied with a dry fingertip and pressed on to the bleeding wound. It should be left in place until the bleeding stops and the remaining strip should then be carefully peeled off and discarded.

Some of the strip may dissolve, assisting in the formation of the gel-like layer over the wound. This

should be left in place to reduce the risk of renewed bleeding.

The Seal-on range was previously exclusive to Boots but distribution has now been widened to independent pharmacies.

Price: £2.59

Pack size: 10 strips
Pip code: 306-4565
Toiletry Sales Ltd
Tel: 01924 250017

The shape of things to come

Original Additions is launching two waxing kits specifically for shaping pubic hair.

Wax a Way Shape It! kits offer two variants – The Brazilian which leaves a small 'run-way strip' of hair and The Heart which results in a heart shape.

Price: £5.95

Original Additions
Tel: 020 8573 9907

Did you nose that... Otrivine provides powerful relief for congestion – lasts up to ten hours?

No-one knows noses like Otrivine®



Contains Xylometazoline Hydrochloride

A NEW APPROACH TO **Pain Relief**



Kool 'n' Soothe is ideal to use at the first sign of a fever or high temperature to deliver comfort to children.

It is safe to use with other medication.

Kool 'n' Soothe Migraine can be used at the first sign of a migraine or a severe headache as part of a migraine management programme.

It is safe to use with other medication.



Cura-Heat is an air activated heat pad suitable for Back, Shoulder or Neck pain providing 12 hours of warming relief.

Leading Innovation in Topical Solutions
By Kobayashi Healthcare Europe

Sporty campaign

Seven Seas is targeting people who play sport or exercise intensively with a new £250,000 campaign.

Running until the end of the year, the campaign will include posters in 200 gyms plus press advertising in sports and keep fit magazines.

Stylized sports images are designed to reinforce the link between original NeutraTaste Cod Liver Oil capsules and NeutraTaste SportFlex.

The advertising for Original NeutraTaste Cod Liver Oil focuses on women who keep fit, while NeutraTaste SportFlex is targeted at sportsmen.

Both advertisements highlight parts of the body claimed to feel the benefit of taking the supplements and carry the strapline



'You know you've taken it, Your tastebuds don't.'

For more information:

Seven Seas Ltd
Tel: 01482 375234

TV

Sponsored by



Accu-Chek: Sat

Askit Powders: GTV, C4, five

Astral Moisturiser: C4, five, GMTV

Benylin All areas

Bisodol: Sat

Blistex: GMTV, Sat

Bodyform: C4, five, GMTV, Sat

Calpol: All areas except U, GMTV

Clever White: GMTV, Sat

Horlicks: B, G, Y, C, TT, C4

Kool'n'Soothe: All areas except C4, five

Kool'n'Soothe Migraine: All areas except C4, five

Lucozade Energy: All areas except U, CTV, GMTV

Meltus: five, GMTV, Sat

Multibionta: C4, Sat

Nytol: All areas except U, GMTV

Olbas for Children: five, GMTV

Olbas range: five, GMTV, Sat

Radox aromatic bath essence: All areas

Radox herbal bath: All areas

Strepsils: All areas except U, GMTV

Ymea: G, Sat

Zovirax: C4, five, Sat

PharmaSite for next week: Ibuleve – window, Ibuleve – in-store, Vicks Medinite – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, Five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Garfield makes a splash with shampoo

MPM Consumer Products is running a Garfield The Movie promotion for its Kids-Zone shampoo to coincide with the film's DVD/VHS release date of November 26.

The promotion will appear across four varieties of Kids-Zone 2-in-1 Shampoo – Melon & Banana, Tropical Fruit, Cherry-Almond and a new variant called Splash of Fizzy Cola.

Consumers have the chance to win a holiday for four in Florida in an on-pack competition. There are also 100 runner-up prizes of Garfield wallets.

The promotion will run until January 2005.

For more information:

MPM Consumer Products
Tel: 0161 231 6111

Supplement for mature skin

Ferrosan is launching a dietary supplement designed to address the skincare needs of women after the menopause.

Imdeen Prime Renewal tablets contain marine and soy extract, vitamin C, vitamin E, white tea and grape seed extract, lycopene and zinc.

The tablets are claimed to help improve skin firmness, stimulate the regeneration of collagen and the renewal of skin cells and reduce the visibility of fine lines and wrinkles on the forehead and around the eyes and lips.

The tablets come in morning and evening formulations (identified by a sun or moon graphic).

The evening tablet formulation includes camomile.

Two tablets should be taken in the morning and two in the evening daily.

Price: £49.50

Pack size: 120 tablets (one month's supply)

Ferrosan Ltd
Tel: 020 7240 2122

Essential Information

Product Name: Zocor Heart-Pro® 10mg tablets. **Presentation:** Peach-coloured, oval-shaped tablets containing simvastatin 10mg. **Indications:** To reduce the risk of a first major coronary event (non-fatal myocardial infarction and coronary heart disease (CHD) deaths) in individuals who are likely to be at moderate risk (approximately 10-15% 10 year risk of a first major event) of CHD.

Dosage and Administration: Take one 10mg tablet daily at night. Not recommended for paediatric use.

Contraindications: Hypersensitivity to simvastatin or any of the excipients; previous history of muscular toxicity with a statin or fibrates; individuals already taking prescription cholesterol lowering drugs; concomitant administration of potent CYP3A4 inhibitors (e.g. itraconazole, ketoconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin and nefazodone); active liver disease or unexplained persistent elevations of serum transaminases; pregnancy and breast-feeding; women of childbearing potential. **Precautions:** Zocor Heart-Pro® is not intended for individuals who are known to have: existing coronary heart disease, diabetes, history of stroke or peripheral vascular disease, familial hypercholesterolaemia. Individuals with hypertension should consult their doctor before undertaking treatment. Individuals with a fasting LDL-cholesterol level of 5.5 mmol/l or greater should consult their doctor. All individuals must be advised of the risk of myopathy and told to stop taking Zocor Heart-Pro® if they experience unexplained generalised muscle pain, tenderness or weakness. People aged >70 years or with hypothyroidism, renal impairment, personal or family history of hereditary muscle disorders should not take Zocor Heart-Pro® except on medical advice. Product should be used with caution and under medical supervision in people who consume substantial quantities of alcohol and/or have a history of liver disease. If treatment with itraconazole, ketoconazole, erythromycin, telithromycin or clarithromycin is unavoidable, therapy with Zocor Heart-Pro® should be suspended during the course of treatment. Concomitant use with potent inhibitors of CYP3A4, e.g. ciclosporin. Individuals with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. **Side Effects:** Most commonly reported side effects were: abdominal pain, constipation, flatulence, asthenia, headache. The following side effects have also been reported: anaemia, paraesthesia, dizziness, peripheral neuropathy, dyspepsia, diarrhoea, nausea, vomiting, pancreatitis, hepatitis/jaundice, rash, pruritus, alopecia, myopathy, rhabdomyolysis, muscle cramps, myalgia. Apparent hypersensitivity syndrome has been reported rarely. Increases in serum transaminases, alkaline phosphatase and serum CK levels. **Legal Category:** P. **PL Number:** PL 13249/0039. **PL Holder:** Johnson & Johnson MSD Consumer Pharmaceuticals, High Wycombe, Buckinghamshire HP10 9UF, UK. **Packaging Quantities:** 28 tablets. **Price:** £12.99 (RRP). **Date of Preparation:** May 2004.

Too many of your customers don't realise they need your help.

It's time they knew.



you can do more to help people like these:
customers who simply don't realise that they are at moderate risk of a heart attack.
as well as giving them good advice on heart health, you can get them to take positive, preventive
action. When you find that a customer could be at moderate risk, that's a 1 in 10 to 1 in 7 chance of a heart
attack in the next 10 years, you can give them the good news that taking Zocor Heart-Pro® can reduce their
heart attack risk, for example, by about a third over 3 years. Their risk stays lower as long as they continue
to take Zocor Heart-Pro®. We've given you the tools to identify customers at moderate risk, so that you can
help them with Zocor Heart-Pro® without a prescription, as part of a healthy heart programme. Together,
you can start saving lives.



Pump up the volume

The launch of OTC omeprazole will invigorate the gastrointestinal market, as Sarah Purcell reports

In March the first proton pump inhibitor, omeprazole, became available as an OTC medicine in the form of Zantrol for treatment of heartburn symptoms associated with acid reflux. Since then, a string of generic products have quickly followed and industry experts are predicting a shake-up of the heartburn remedies market as more patients are made aware of the benefits of PPIs.

"It's still early days so PPIs haven't made a great impact yet in terms of sales on the heartburn market, but it's given pharmacists a fantastic product to recommend. I think as more of these products become available the price will fall and then we'll see them taking share away from other heartburn remedies simply because they're more effective," says Ajit Malhi, professional services manager at AAH Pharmaceuticals. "In particular I think we'll see them take away share from H₂ antagonists."

At UniChem, NHS development manager for pharmacy and retail, Mike Holden, agrees: "It will be H₂ antagonists that are affected most as PPIs deal with heartburn symptoms more effectively. And think because we've seen generic products launched so quickly, competition has already been created and it won't be long before we see prices drop."

Greg Bertolotti, marketing manager at GSK, says the effects will take time to filter through. "The heartburn market has seen little change over the past five years and it'll take some time for pharmacists to get used to recommending the new products. I think we'll see traditional antacids continue to decline, but won't be a simple case of consumers switching products. Because PPIs don't give instant relief, consumers may still continue to use antacids as well."

He believes there's lots of room for growth in the heartburn market: "We know that one in three people suffer from recurrent heartburn but many of these don't treat their symptoms."

"Pharmacists are now in a very strong position because the new PPIs are only available from pharmacies – it's a great chance for them to give patients advice and help them to re-evaluate their heartburn treatment," says Mr Bertolotti.

The move will encourage more patients to go to their pharmacist for a heartburn remedy rather than their GP, which is all part of the Government's plan to broaden the pharmacy role. It's also hoped that it will cut the prescribing budget – in 2002 the NHS spent £403 million on PPIs. "As awareness of PPIs is raised by pharmacists, more people will turn them before going to see their GP because it's more convenient than having to wait days for an appointment," says Mr Malhi. "Pharmacists are really excited about this opportunity, as with the right screening they'll be able to help more patients with heartburn."

At UniChem Mr Holden agrees: "The switch to P status has put pharmacists in a strong position, though they will be very closely monitored to see how they

Continued on page 44

Tackle the taboo

Every other customer who enters your pharmacy potentially could develop piles at some stage of their lives, according to the Department of Health. Yet very few will seek help because the subject is one of the last taboo's in our society, and remains, unfortunately for sufferers, the 'butt' of many a joke



and pile on the pounds with Anusol

At the moment, two thirds of those with piles suffer in silence¹; they are either too embarrassed to seek help or they don't realise treatments are so readily available. In a bid to rectify this situation **Anusol**, brand leader in the haemorrhoid treatment market with a 47% pharmacy share², is launching an extensive 'One out of two' campaign to highlight the prevalence of this condition and to encourage sufferers to identify their symptoms and obtain relief from their local pharmacy. As well as press advertising in key consumer and national titles, the initiative will be supported with dedicated public relations activities and direct marketing.

Knowledge is power

To ensure your pharmacy is prepared, staff should familiarise themselves with the treatment options available and the specific actions of each. For example, every product within the **Anusol** range contains an astringent to soothe and protect raw areas and help shrink swollen tissue while added antiseptics reduce the risk of infection and encourage healing. For piles that have become inflamed, painful or intensely itchy **Anusol Plus HC** has added hydrocortisone to reduce inflammation, providing rapid, soothing relief. Available exclusively through pharmacy, **Anusol Plus HC** is offered in two delivery formats; an ointment or suppositories which deliver a measured dose directly inside the back passage.

Staff can also download a copy of the pharmacy protocol on piles from educational website, www.pilesadvice.co.uk. Produced by **Anusol** in conjunction with the National Pharmaceutical

Association (NPA) it outlines the WWHAM protocol to help ensure the most suitable course of action is recommended.

Customer choice

To maximise sales, category management should also be reviewed since research has shown that over two thirds of sufferers would still prefer to self-select quietly from the shelves¹. To help these consumers make an informed decision about their condition and the types of remedies available **Anusol** will be offering specific point of sale materials, shelf wobblers and leaflets. These can be ordered by calling **01737 332 255** or via www.comedis.com.

What you can do to help conquer the taboo surrounding this lucrative category...

- Help normalise the condition by not hiding remedies away. Displaying treatments openly in the main body of the store increases the prominence of the category and makes them more accessible for customers who wish to browse.
- Provide good clear educational material to enable customers to make informed decisions and buy the right treatment for their condition, while minimising embarrassment. Take advantage of the support materials **Anusol** has on offer.
- Reassure customers that piles is a perfectly normal, and in fact, very common condition. Address the issue with confidence but respect customers privacy and exercise discretion by taking them to a quiet area of the pharmacy.

References: 1. www.pilesadvice.co.uk 2. IMS Data

Product Information

Anusol Cream, Ointment & Suppositories: Presentation: Cream, Ointment and Suppositories. Cream: Each 100g contains Bismuth oxide 2.14g, Balsam Peru 1.8g, Zinc oxide 10.75g Ointment: Each 100g contains Bismuth subgallate 2.25g, Bismuth oxide 0.875g, Balsam Peru 1.875g, Zinc oxide 10.75g Suppositories: Each suppository contains Bismuth subgallate 59mg, Bismuth oxide 24mg, Balsam Peru 49mg, Zinc oxide 296mg. Uses: Symptomatic relief of internal and external (cream and ointment only) haemorrhoids and other related ano-rectal conditions. Dosage: Apply cream or ointment or insert one suppository to the affected area at night, in the morning and after each evacuation until the condition is controlled. Not recommended for children. Contraindications: Hypersensitivity, Pregnancy and Lactation: Consult doctor before use. Side effects: Rarely, sensitivity reactions; occasionally transient burning on application. RRP (ex VAT): Cream 23g £3.29; 43g £5.19; Ointment £4.19; Suppositories 12s £3.09; 24s £5.49 Legal category: GSL. PL Holder: Pfizer Consumer Healthcare, Chestnut Avenue, Eastleigh, SO53 3ZD. PL Numbers: Suppositories 15513/0043 Cream 15513/0041 Ointment 15513/0042 Date of preparation: August 2003

Anusol Plus HC Ointment and Suppositories: Presentation: Ointment and Suppositories. Ointment: Each 100g contains: Hydrocortisone acetate 0.25g, Benzyl benzoate 1.25g, Bismuth subgallate 2.25g, Bismuth oxide 0.875g, Balsam Peru 1.875g, Zinc oxide 10.75g Suppositories: Each suppository contains: Hydrocortisone acetate 10mg, Benzyl benzoate 33mg, Bismuth subgallate 59mg, Bismuth oxide 24mg, Balsam Peru 49mg, Zinc oxide 296mg. Uses: Symptomatic treatment of internal and external (ointment only) haemorrhoids and pruritus ani. Dosage: Adults over 18 years: Apply ointment sparingly to affected area or insert one suppository, in the morning, at night and after each evacuation up to 4 or 3 times a day, respectively. Contraindications: Tubercular, fungal and most viral lesions. Sensitivity to any of the constituents. Precautions: Prolonged or excessive use may produce systemic corticosteroid effects. Consult a doctor if rectal bleeding occurs. Pregnancy and Lactation: Consult doctor before use. No special precautions in lactation. Side effects: Rarely sensitivity reactions. Occasionally transient burning on application. RRP (ex VAT): Ointment £3.50; Suppositories 12s £4.35 Legal Category: P. PL Holder: Pfizer Consumer Healthcare, Chestnut Avenue, Eastleigh, SO53 3ZD. PL Numbers: Ointment 15513/0039 Suppositories 15513/0040. Date of preparation: August 2003.

Anusol

For product information, contact Pfizer on **01737 332 255**.

The Anusol range consists of **Anusol** and **Anusol HC**. **Anusol**, for mild sufferers, has suppositories, ointment and cream. **Anusol HC** is intended to relieve more severe piles and has suppositories and ointment in the range.

Anusol Cream, Ointment & Suppositories Product Information RRP (ex VAT): Cream 23g £3.29; 43g £5.19; Ointment £4.19; Suppositories 12s £3.09; 24s £5.49 Anusol Plus HC Ointment and Suppositories Product Information RRP (ex VAT): Ointment £3.50; Suppositories 12s £4.35

are managing it and to ensure they are following the protocol properly and recommending PPIs to the right patients." Pharmacists need to take a three-step approach to managing heartburn, he believes:

1. Give patients advice on ways they can prevent heartburn by making changes to lifestyle and diet.
2. Help them to manage symptoms quickly, and for this antacids should still be recommended.
3. Help them to control recurrent heartburn by recommending more effective products such as H₂ antagonists and now PPIs.

When to recommend PPIs

Omeprazole works by suppressing gastric acid secretion in the stomach. It suppresses the final stage of gastric hydrochloric acid production by blocking the hydrogen-potassium ATPase enzyme (the proton pump) in the cells of the stomach wall. They give 24-hour control of symptoms if taken daily.

PPIs can be recommended as follows:

- As first-line therapy for heartburn sufferers who have recurring symptoms (two or three times a week or more).
- Patients can be recommended an antacid to take to give immediate relief as omeprazole takes a couple of days to start working.
- PPIs should not be taken in conjunction with H₂ antagonists.

Prescribing protocol

"I don't think there is a danger of more serious conditions being missed because of PPIs being wrongly recommended. As long as pharmacists ask the right questions they will be alerted to any potential problems and refer patients. The fact that customers are talking to a health professional about their symptoms instead of just picking up a remedy in the supermarket has to be a huge advantage. The real problem arises when consumers get their remedies from a grocery shelf and don't get any advice at all," says Mr Malhi.

Patients who should be referred to a GP include:

- Over 45s who have new or changed symptoms.
- Anyone with heartburn plus unintentional weight loss, GI bleeding, vomiting blood, anaemia or jaundice.
- Anyone with a previous peptic ulcer or surgery.
- Pregnant or breast-feeding women.
- Any suspicion of cardiac pain.
- Anyone who's been taking antacids continuously for four or more weeks for heartburn or for two weeks with no relief of symptoms.
- Anyone with a significant medical condition.
- Patients with long-term recurrent heartburn should see their GP at regular intervals.

It's essential to ensure that the patient really does have heartburn. It is a chronic, intermittent, relapsing condition and causes an acidic or burning sensation behind the sternum. The pain may radiate to the throat and back. Acid regurgitation is a common symptom with heartburn. The pain is made worse by eating large meals, bending over or lying flat.

Heartburn an

Zanprol, the first PPI launched, is being supported by a £1.1 million advertising campaign which continues until Christmas.

GSK is also putting heavy support behind Zantac 75 in the form of TV and press advertising. GSK, tel: 0208 047 2700.



AAH Pharmaceuticals has added omeprazole tablets to its Vantage range. The 10mg tablets retail at £6.49 for 14 tablets.

AAH Pharmaceuticals, tel: 02476 432000.

Pepto-Bismol has been proven to treat heartburn symptoms as well as indigestion, upset stomach, nausea and diarrhoea. Remaining in the stomach for at least half an hour, it coats the GI tract, protecting the stomach lining from irritants.

Procter & Gamble (Health Beauty & Cosmetics), tel: 01932 896000.



Setlers Antacid tablets is being backed by a national TV campaign over the festive season. Consumers will be reminded that "Setlers bring express relief".

Thornton & Ross, tel: 01484 848200.

Gaviscon Cool is the latest variant to be added to the Gaviscon range. The peppermint flavour gives an immediate cooling sensation and it's available in liquid and tablet form.

Reckitt Benckiser, tel: 01482 3261510.

Soothe the Groans

Asilone Antacid Liquid contains Light Magnesium oxide 70mg, Aluminium hydroxide 420mg and Activated dimeticone 135mg. Classification: GSL. Indications: relief of dyspeptic symptoms. Warnings: not recommended in persistent abdominal distension and related to intestinal obstruction. Further information: from Thornton & Ross Ltd, Unit 10, Huddersfield HD7 5QH



digestion product news


Bring on the



Bisodol
Indigestion Relief
Rapid and lasting ant-acid formula
Rapid relief from indigestion
Rapid relief from heartburn
Rapid relief from wind
Original Peppermint Flavour

No other indigestion tablet acts faster
Always read the label

In a recent study, Gaviscon Advance was found to give heartburn relief in up to 90 per cent of women suffering heartburn in pregnancy. A recent stepped protocol to manage dyspepsia in North Lincolnshire PCT found that Gaviscon Advance played a significant role in stepping patients off maintenance dose PPIs. Up to 58 per cent of patients had their symptoms controlled on Gaviscon Advance throughout a period of 10 months.
Reckitt Benckiser, tel: 01482 3261510.



Heartburn Relief 10mg Tablets
omeprazole
Advanced treatment
Up to 24 hours
14 Tablets

Thornton & Ross has launched a 10mg omeprazole tablet in its Care range, retailing at £5.99 for 14 tablets. The launch is being supported by a consumer press campaign this autumn. An education programme for pharmacy staff is available. Thornton & Ross, tel: 01484 848200.



TRUSTED BRAND
2004
Reader's Digest

Roche is backing Rennie this autumn with a £1 million TV campaign, highlighting the great taste of Rennie Soft Chews. Rennie accounts for 41 per cent of the indigestion products market. Roche Consumer Health, tel: 01779077 366000.

- Did you know?**
- Digestive diseases account for one in eight deaths in the UK.
 - One in four main operations in UK hospitals are connected with the GI tract.
 - Over a third of the population regularly suffers from a digestive illness, including IBS, constipation, diarrhoea, nausea and stomach ache.
 - Anxiety about digestive diseases and conditions ranked second to last in a nationwide survey done for national Gut Week.
 - An estimated 200 million people around the world, on any given day, suffer from diarrhoea.
 - Over three million people in the UK suffer from constipation every month.
 - One in 10 men and 1 in 15 women suffer with ulcers.
 - Ulcerative colitis and Crohn's affects 150,000 people in the UK.

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with Asilone



Acid indigestion, heartburn, trapped wind - to your customers it's simply a groaning tummy. Asilone offers fast relief - that's why customers come back for Asilone whenever the groans need soothing. Recommend Asilone - a quick and simple solution for whatever the indigestion problem.

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Constipation

A survey by Dulco-Lax has found that GPs and practice nurses spend a total average of 100,000 hours advising patients on constipation every week, at a cost to the NHS of £65 million a year. Pharmacists spend 21,000 hours every week giving patients advice on the condition, seeing 41 per cent of constipation sufferers.

While constipation can affect anyone at any time, the elderly tend to suffer most frequently. The reasons for this are immobility, not eating

enough fibre or getting enough fluids. The other main groups that suffer badly are pregnant women, due to hormonal changes which slow the digestive process down as well as taking iron supplements, and patients with limited mobility. Poor diet is also a major cause – not eating enough fibre or fluids, coupled with lack of exercise and a stressful lifestyle.



New to the Dulco-Lax range are Dulco-Lax Perles, a GSL product, which aims to tackle the embarrassment factor by allowing customers to self-select. The brand is being supported by a £2m TV campaign. Boehringer Ingelheim, tel: 01344 424600.



Overindulgence remedy on offer

Weleda is offering a special six for five promotion for pharmacists in the run-up to Christmas on its Melissa Comp drops. Melissa Comp is a traditional herbal remedy for nausea and upset stomach caused by overindulgence of food and drink. Ingredients include melissa, lemon balm, nutmeg, cinnamon, clove, angelica root and coriander.

Ex-Lax Senna pills have seen good growth in pharmacy, with sales up by 64 per cent last year (IRI). Ex-Lax is available as a sugar-coated pill or as Senna Chocolate, making it pleasant to take. Novartis Consumer Health, tel: 01403 210211.



Fybogel has been reformulated with an improved taste and is now easier to disperse in water. This has been achieved by using shorter ispaghul polymer to ensure it stays in liquid form for longer. It's available in orange, lemon or plain. Reckitt Benckiser, tel: 01482 3261510.

Diarrhoea retains embarrassment factor

Research by Johnson & Johnson MSD has revealed that diarrhoea is a complaint that consumers are becoming more confident about self-treating, but there is still an embarrassment factor associated with purchasing remedies to treat it. J&J MSD recommend that pharmacists place small GSL packs on display, such as Imodium Instants or Imodium Plus caplets, to make it easier for consumers. J&J MSD, tel: 01494 450778.



Promotion

Brand focus

Zanprol Tablets were launched in March 2004 as the first over-the-counter (OTC) omeprazole brand, and is set to revolutionise the management of heartburn. With easy access to **Zanprol**, recurrent heartburn sufferers can now not only benefit from effective relief of heartburn, but **Zanprol** can also give sufferers weeks of remission from recurrent attacks (after a short course of 2-4 weeks).

Zanprol 10mg Tablets help stop the production of excess stomach acid giving the oesophagus time to heal. This makes omeprazole highly effective in the relief and remission of recurrent heartburn as demonstrated by numerous clinical trials^{1,2}

and 15 years of prescription use in millions of patients.

Recurrent heartburn can have a significant effect on people's quality of life, and it is predicted that **Zanprol** will encourage a much-needed re-evaluation of its treatment. Consumer knowledge of heartburn and **Zanprol** is being driven by the launch of a new website – www.heartburnrelief.co.uk, national press advertising, and direct mail, along with a money-off coupon to encourage trial.

Legal status: P

Further information is available from: GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, UK



References

1. GlaxoSmithKline SPC 2003
 2. Bardhan KD, BMJ 1999; 318: 502-507
 3. Chiba N, Gastroenterology 1997; 112: 1798-1810.
 4. Bate CM, Aliment Pharmacol Ther 1997; 11: 755-763.
- ZANPROL is a registered trade mark of the GlaxoSmithKline group of companies.

Flora and **disorder**

As awareness about irritable bowel syndrome grows, a potentially helpful role for probiotics has been investigated, but with mixed results, reports Sarah Purcell

Irritable bowel syndrome is the UK's commonest digestive disorder, with 13 per cent of us affected at some time and it's thought that 10 per cent of GP consultations and half of all referrals to gastrointestinal clinics are due to IBS symptoms. But we still don't fully understand the causes of IBS and doctors differ

on how they treat the condition.

Many patients become disillusioned with conventional treatments and it's thought that 70 per cent don't seek medical help. In recent years probiotics have been used increasingly by patients to treat and help prevent IBS symptoms, but can they really do any good?

One popular theory about IBS is that sufferers have altered intestinal flora, and in particular lower counts of lactobacilli, eoliforms and bifidobacteria than non-sufferers. It's still unclear whether this is a cause of or an effect of IBS.

"What we do know is that when people travel abroad and pick up gastroenteritis, some develop IBS afterwards and there is often a change in gut flora," says Professor Colette Shortt, lecturer at the University of Ulster and scientific director of Yakult. One study found that a quarter to a third of IBS patients had had infectious gastroenteritis, while another study

found that people who'd had an acute attack of gastroenteritis were 10 times more likely to develop IBS. "The theory is that the infection produces an inflammatory reaction and this causes gut hypersensitivity," says Professor Shortt.

"We have a lot of testimonies from patients that say probiotics do help relieve their IBS symptoms, but not much objective evidence," says Dr Nick Read, gastroenterologist and medical advisor to the IBS Network. "However, there is strong evidence to suggest that IBS has an inflammatory component and this may set up an allergic reaction. Giving probiotics may help prevent the inflammation and its resulting effect on the gut."

The thinking behind the use of probiotics is that they can modulate the gut flora by introducing the right types of bacteria. In a review of 12 clinical trials, 10 found beneficial effects from probiotics for at least one

IBS symptom and five were especially convincing. It's thought that the benefits are due to recolonisation of the intestines with more suitable flora. One clear advantage of using probiotics is the lack of side effects, so there's nothing to be lost by trying them out.

Which products?

Probiotics are available as milk drinks, yoghurts, juice and supplements. All of these can be effective, but the important thing is whether they contain sufficient live bacteria. Some experts believe that using a milk base helps to protect the bacteria from damage by the stomach acid. Dr Read advises using soy or oat-based probiotics for patients who're allergic to lactose.

At present there are no guidelines on recommended daily dosage, and how much you need will depend on the type of probiotic used. An FSA study is

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Full and bloated?

When your customers should be full of Christmas cheer, offer them...



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PSNC proclaimed the new contract 'brilliant' for community pharmacy at its annual conference in Manchester last Wednesday and health minister Rosie Winterton gave it her full support in a keynote speech, reports **Gary Paragpuri**

New contract, new era

Because the existing pharmacy contract has no quality measures, a pharmacy with no competitor nearby can meet its contractual requirements with the barest level of service, Sue Sharpe, PSNC chief executive, told delegates.

This has not been good for anyone and the new contract will address quality of service provision, she told the 800-strong audience, which included 350 PCT representatives.

Following the Government's indication that it wanted to reward "quality and not volume" under the new contract, PSNC developed proposals for fees and allowances to reflect the cost of pharmacies with different dispensing volumes and "offer a fair return to small and large pharmacies", Mrs Sharpe said.

The funding calculations are based on independent pharmacies' costs and incomes and the arrangements for future years should protect the basis of this, she explained. There will also be periodic reviews,



which should "prevent a lapse into the position that we have now where the official funding – the global sum – is way adrift of the cost of providing the service, let alone providing any return on the pharmacy's

"We are pleased with the funding. It provides what we were determined to secure"

Sue Sharpe

investment", she added.

"We are pleased with the funding. It provides what we were determined to secure: fair funding for the community pharmacy NHS service, and it provides it for pharmacies large and small."

Addressing the concerns of low volume pharmacies who do not meet the contract's prescription threshold levels for extra payments, Mrs Sharpe explained: "There are inevitably within a total of more than 10,500 pharmacies, some small pharmacies with peculiar local circumstances. National arrangements cannot deal with specific local problems, and so we have agreed we will develop with our negotiating partners, the DoH and the NHS Confederation, a standard form of

Contractor checklist

Things to do in preparation for the new contract:

1. Brief staff on the new contract
2. Assess your readiness for providing essential services
3. Assess staffing requirements
4. Assess training and development needs for all staff
5. Decide whether you want to provide advanced services early on
6. Assess premises in light of contract requirements, such

as consultation areas

7. Start thinking about future IT requirements
8. Develop an action plan, in conjunction with staff, to make any necessary changes to pharmacy procedures
9. Assess relationships with other local healthcare professionals
10. Think about enhanced services provision and monitor local activity
11. Work with the LPC

LPS to provide protection for those.

"These are the pharmacies that have a limited potential patient population but provide a valuable service that we must retain. PCTs will be able to secure continued services by using the LPS, and the pharmacies will get secure income levels."

Turning to the new control of entry regulations that will accompany the new contract, Mrs Sharpe said: "It will be wrong to pretend that this is welcome, particularly for contractors who see a programme of change with this contract. But the Government has acted to reduce the worst impacts of its earlier proposals and we're grateful for that."

Mrs Sharpe also touched on the new out-of-hours arrangements for PCTs. She said pharmacy is already feeling the impact, with increased requests for emergency supplies as patients experienced difficulty in getting prescriptions.

"We do remain worried that the new arrangements for out-of-hours supply of medicines are making extended pharmacy opening hours quite simply unviable. In many areas this could become a real problem and local arrangements will need to be made between PCTs and LPCs," she warned.

Mrs Sharpe also announced that minor ailments were expected to become part of the essential service framework soon.

Although PSNC will encourage contractors to use the period from February to April to prepare for the new contract by providing implementation support for pharmacists and for LPCs, Mrs Sharpe added that PCTs also need to gear up to undertake their role.

Community pharmacy had reached a historic moment, said minister Rosie Winterton to the audience.

But the *NHS Improvement Plan*

promised even more radical developments backed by significant NHS investment, she said. "With £90 billion plus being spent on the NHS by 2007-08, we must make sure that that investment is backed up by modernisation and reform. People will want to see 21st century services meeting their needs," she added.

The minister expressed a desire for an NHS that put patients at the centre of services and was



"Community pharmacy is first and foremost a clinical healthcare profession – not another retail identikit"

Rosie Winterton

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"I've been over doing it a bit with all these Christmas parties and have been feeling discomfort after eating. I think I may be suffering from 'indigestion', can you recommend something to ease the pain?"

Patients often use indigestion as a catch-all phrase to cover any discomfort in the upper gastrointestinal (GI) tract when they could be suffering from other GI conditions such as heartburn. As it is not always easy to diagnose despite careful questioning, it's helpful to recommend a multi-symptom product that covers common upper GI complaints, should the patient's description be inaccurate. Unless there is some underlying disease such as a hiatus hernia, indigestion is usually a result of over-indulgence and can be more prevalent around the festive period when people are eating richer food and drinking more alcohol. The symptoms are discomfort in the upper abdomen, bloating and possibly nausea. Although relatively harmless, indigestion can make patients feel miserable.

Pepto-Bismol is a multi-symptom remedy for most common GI complaints. It is very effective at treating indigestion as a stand alone complaint, but can also treat the associated symptoms of over indulgence such as heartburn, nausea, an upset stomach and diarrhoea. Pepto-Bismol's active ingredient, Bismuth Subsalicylate, works directly on the GI tract and offers effective, rapid relief due to its unique triple action formula.

Pepto-Bismol's demulcent base has a coating action which soothes and protects the GI tract against further irritation. This can provide rapid relief from indigestion without interfering with the stomach's natural digestive processes.

Nausea and diarrhoea may also occur with indigestion. **Pepto-Bismol** inhibits the cause of infection by its anti microbial action. Bismuth Subsalicylate, the active ingredient in **Pepto-Bismol** works by inactivating bacteria that cause diarrhoea and stomach upsets as well as reducing fluid flow into the GI tract via its anti-secretory action by inhibiting prostaglandin synthesis. In this way **Pepto-Bismol** helps treat the root cause of the problem.

Pepto-Bismol's unique active and triple action formula gives fast, effective and safe relief from indigestion and associated side effects without the need to take several medicines.

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Abbreviated Prescribing Information for Pepto-Bismol:

Active ingredient: Bismuth Subsalicylate 1.752 %w/v
Indications: For heartburn, upset stomach, indigestion and nausea. Controls common diarrhoea. Dosage and administration: Adults: 16 and over: 30ml (6 x 5ml spoonfuls) Repeat dosage every half to one hour if needed. No more than 8 doses to be taken in 24 hours. Contraindications: Patients sensitive to aspirin. Precautions, side effects and warnings. Not to be taken with aspirin. Pepto-Bismol should not be used by those aged under 16 due to a possible association between salicylates and Reye's syndrome, a very rare but very serious

disease. Use in pregnancy should be avoided. Use with caution in patients taking anti-coagulants or oral therapy for diabetes or gout. May cause a temporary darkening of the tongue and/or stool. If symptoms are severe or persist for more than 2 days a doctor should be consulted. Do not exceed the stated dose. Keep all medicines out of the reach of children. Product licence number: PL 0364/0027. Product licence holder: Procter & Gamble (Healthcare) Limited, Rusham Park, Whitehall Lane, Epsom, Surrey TW20 9NW. Legal category: P. Price (excluding VAT): 1.2.54 (120ml), £3.82 (240ml), £5.78 (480ml). Date of preparation: May 2004

PSNC Community Pharmacy Conference

accountable to them. She wanted more support for people with long-term health conditions and a greater focus on reducing health inequalities.

Describing pharmacy as an "indispensable element in primary care delivery", Ms Winterton said the fact that the new pharmacy contract mirrored the new GP contract indicated pharmacy's integration within the NHS. Further, the range of services within the contract "sends the clearest possible message that community pharmacy is first and foremost a clinical healthcare profession – not another retail identikit".

To ensure the contract's success, Ms Winterton announced a programme of support for PCTs including guidance on the contract framework and on control of entry reforms. Other support for PCTs includes: toolkits to help them carry out pharmaceutical needs assessments; the development of strategic tests to guide the monitoring of the implementation of the new framework; and

After speaking at PSNC's conference, health minister Rosie Winterton visited Lloyd's pharmacy in Fallowfield. She is pictured with, back row from the left: Janine Martin, Mohammed Al-Mobarak, John Gibson, Martin Smart; middle row: Tracey Jones, Imreen Hussain and, at the front, Angela Lonsdale

training for pharmacists and staff in areas such as repeat dispensing and risk management.

Turning to the Government's 'balanced package of measures' for reforming control of entry, she said: "I know there were worries. But we have made changes. The right competitive edge will still be there for existing contractors to enhance service delivery and new entrants to fulfil unmet needs. But there will be checks and balances to ensure community pharmacies' vital role is maintained, safeguarding, in particular, ready access to pharmacies in poorer and rural areas."

Ms Winterton warned that control of entry must remain a "tool to securing our aims and not an end in itself".



The Q&A session

Q David Kent, Camden & Islington LPC: "My LPC has the highest number of contractors in the 1,100 to 2,000 prescription item range. They, in three years, will suddenly find between £9,300 and £18,000 of their remuneration taken away from them, apart from the small practice payments. On what basis have you done this?"

A Sue Sharpe, PSNC: "Present thresholds will change but there will be, for three years, protection, and a number of things may occur in those three years: with the introduction of repeat dispensing there will be a significant increase in prescription numbers.

Pharmacies that have patients who are on three-monthly prescriptions may find a disproportionate increase in their prescription numbers as a result of that.

"But I think the most important issue is the opportunity to develop the use of LPCs where you have particular local problems, where you have a high loading of very small volume pharmacies but where you have particular patient and population characteristics that mean you need, and can make, a good case to sustain a network of very small pharmacies.

"That is the way in which, with this new spirit of integration, co-operation and collaboration, LPCs and PCTs can meet together and really address how they can ensure that their communities continue

"It's very important that those pharmacies making use of changes to control of entry are viable"

Jeanette Howe



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PSNC contract negotiating team members Dhiren Bhatt, left, and Raj Patel take part in the conference

A Jeanette Howe, DoH: "In negotiating the new contract we have been aware that we need to make good use of pharmacy staff. Pharmacists can't deliver all of this on their own and we don't expect them to. We expect pharmacists to use pharmacy technicians and other support staff in repeat dispensing, public health activities, and supporting self-care. Skill mix is something the DoH wants to encourage and we hope to publish a consultation document on that in the not too distant future."

Q "If the contract is based on quality why do we need to have a threshold for payments?"

A Jeanette Howe, DoH: "In negotiating the new contract, we need to ensure value for money for taxpayers, patients and the NHS, and a fair contract for pharmacy. When one considers the costs of pharmacy there are a number of fixed costs that one has to take account of, and we also have changes to control of entry. And so we may see new pharmacies coming on stream and it's very important that those pharmacies making use of changes to control of entry are viable. Those are the sorts of factors that need to be taken into account within negotiations."

Q Bruce Allan, Worthing: "Are the panel at all hopeful that cash-strapped PCTs will commission any enhanced services and if so why?"

A Alastair Buxton, PSNC: "We are already seeing a lot of interest from PCOs moving towards commissioning these enhanced services but I will not pretend that in the next 12 months particularly it's not going to be difficult. An issue to bear in mind is that PCOs are now being given the tools to actually start moving some of the services out

of secondary care – by payment by results, looking at developing patient care pathways – and pharmacists have a big role to play in that."

Q Peter Badham, Badham Pharmacy: "What is the long-term future of the dispensing fee?"

A Sue Sharpe, PSNC: "The future of the different fees and allowances and how we structure the payment will be for discussion over the years. The important issue is that pharmacy contractors will get the system and structure of funding and we have agreed formulas for future years to ensure funding keeps pace and continues to provide fair return for pharmacists. Whether the way in which the annual uplifts in funding is going to be increasing the level of the dispensing fee or increasing the level of the practice allowance or changing the levels of establishment payments is something we will need to keep under review. The important thing is that contractors will still continue to get fair funding for the pharmacy service in future."



"We are aware of the stock issue and we will be tackling the DoH straight away on it"


Steve Williams

at the right range, mix and accessibility of local services to meet their needs."

Q Coll Michaels, Bedfordshire LPC: "Today there has been an announcement about PPRS capping in with a 7 per cent price reduction. Can you assure us that PSNC is on the case for compensation for persisting stocks?"

A Steve Williams, PSNC: "PSNC is on the case. We are aware of the stock issue and we will be tackling the DoH straight away on it. The new contract guarantees £500m – as if the market was entirely independent including money we take on branded [drugs] and PIs, and any influence that changes to PPRS has on that will be included within mechanisms to ensure that money is delivered. "So the new contract helps the problem of PPRS but the old contract doesn't, and we will be going to the DoH straight away to ensure that the stock issue is addressed."

Q Tony Schofield, South Shields: "When this contract comes in will we be able to be in our consultation areas doing medication reviews while our staff are dispensing prescriptions?"



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PSNC chief executive Sue Sharpe answers further contract questions

At the IPMI conference (*C&D*, May 1, 2004, p21), Steve Williams said it was absolutely untrue that the new contract would abandon small pharmacies and that contract negotiations would reward small and large contractors equally but the contract's 2,000 monthly threshold means that those who fail to reach this will not receive the fair funding element of the contract – why?

PSNC has not abandoned small contractors. The thresholds for the new establishment payments provide greater support for pharmacies dispensing over 2,000 items and, for the first three years,

pharmacies dispensing between 1,100 and 2,000 items will also receive increased funding. PSNC spent a great proportion of its September meeting seeking to find ways of providing support for the smallest dispensing pharmacies, taking Government concerns into account.

C&D understands that PSNC board members did not vote on setting threshold levels – they only discussed, in April, how the contract funding could be distributed and at what points the contract would (a) meet contractor's costs and (b) offer fair funding. But the threshold was adopted as policy in September – why was no vote taken on where the thresholds should be?

PSNC worked on distribution options in four groups, to enable detailed consideration to be given

to the options. These groups discussed options at length. Three of the four groups agreed on one of the proposed distribution arrangements. Following discussion in the full Committee, a question was raised whether further debate was needed. A vote was taken on whether to go forward with the clear majority view or have further debate, and a majority voted against further debate as it was evident that there was a substantial majority in favour of the way forward.

At the PSNC conference, you said the contract funding distribution was developed to "offer a fair return to small and large pharmacies", and highlighted how the standard form LPS could be used to safeguard smaller pharmacies. But how will the LPS be funded? Is there any guarantee that PCTs will agree to pay for the standard form LPS? Could GPs use their influence on PCTs to ensure that pharmacies attached to GP surgeries are funded instead of community pharmacies?

LPS will be funded, as now, partially from global sum monies

with additional funding from the PCT. As PSNC has made clear, contractors who wish to convert to LPS will need to make the case to their PCT; there is no guarantee of the PCT's decision. But a pharmacy that is providing a valuable service to a local community should be able to develop a strong case for continuation, with support from its patients. It is of course within the bounds of possibility that GPs might act as the question suggests, but I would expect the voice of patients to predominate.

Why is the exit payment restricted to one year but the current practice payments are guaranteed for three years?

In both cases these are the best options PSNC could negotiate; other government departments had an interest in these issues.

Are thresholds anti-competitive?

I do not have the expertise in this area of law, but I imagine the Department of Health is satisfied that the proposals, in which it has been closely involved, are permissible. If they are not, then abandonment of the front-loading elements would disadvantage many more pharmacies.

Promotion

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What is Cura-Heat?

Cura-Heat is an air-activated heat pack that provides targeted warming relief from back, shoulder and neck pain. The heat radiates to the source of pain, increasing circulation, decreasing stiffness and relaxing sore muscles when the pack is attached to clothing/underwear over the painful area.

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When can Cura-Heat help?

Cura-Heat is ideal to use with back or shoulder/neck pain. It can provide constant comforting heat to relieve the aches and discomfort associated with back, shoulder or neck pain.

How does Cura-Heat work?

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How long does Cura-Heat last for?

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It takes 20 minutes to warm up and it maintains an average temperature of 50.4 degrees C for a full 12 hours.

Directions for Use

Simply remove the heat pack from the sachet (do not cut).

Peel away the paper strip and apply the pack to clothing/underwear over the painful area. (Do not apply directly onto the skin).

Press firmly in place and the warming therapeutic relief will begin.

NOTE: Full safety and usage information should be followed carefully when using Cura-Heat.

Cura-Heat will take approximately 20 minutes to reach its mean temperature 50.4 degrees C.

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Brand focus

Continued from page 47

underway which is looking at all types of probiotics available in the UK to check whether the information on the labels matches up to what's in the products.

Manufacturers (not surprisingly) usually recommend that probiotics should be taken daily to both control and help prevent symptoms, and if you're taking a yoghurt or milk drink-based product, one a day is the usual recommendation. "If you're having a flare-up of IBS then you need to take probiotics daily, but when symptoms ease I think you can stop taking them – they're not proven to work as a preventive," says Dr Read.

Which symptoms can they help relieve?

The most well documented effects are for the relief of excess gas and bloating by probiotics," says Prof Horrt. "And they can also help prevent diarrhoea."

But opinion is divided. Dr Martin Sarnier, honorary secretary of CORE (the new name for the Digestive Disorders Foundation), is sceptical: "I'm not sure there's enough evidence to prove that

Latest news

Only last week, the *Drugs and Therapeutics Bulletin* reviewed probiotics for gastrointestinal disorders. It was inconclusive about the role of probiotics in IBS, saying that four small studies of four to six weeks and involving 168 people had suggested some reduction in the characteristic symptoms of IBS. However, two eight-week studies involving 49 patients did not appear to improve symptoms.

It concluded: "Many issues need to be clarified before widespread use of antibiotics can be advocated for gastrointestinal disorders, including the optimum regimens, selection of and differences between the available probiotic strains, and the potential dangers of treatment."

probiotics help IBS symptoms yet, though it is being extensively trialled for inflammatory bowel diseases including ulcerative colitis and Crohn's. I don't think taking probiotics will do any harm, but it's still not proven to do any good."



Going to excess

Three quarters of consumers believe the Christmas season is starting earlier each year, suggests a survey commissioned by Alka Seltzer.

One thousand people aged between 18 and 45 were asked in the TNS Omnimas survey whether they would need to take time off following Christmas celebrations, and 5 per cent said they would. Alka Seltzer concludes that the other 95 per cent "simply go on, often nursing the symptoms of headache and upset stomach that are associated with over indulgence".

Alka Seltzer claims pole position as the UK's best-selling "overindulgence brand" with 65 per cent of the overindulgence market in the pharmacy sector (*IRI – headache with upset stomach remedies – volume sales M.I.T. Aug 2004, chemists inc Boots and Superdrug*).

Brand manager Aurelie Avogardie commented: "As the nation starts celebrating Christmas earlier each year and overindulgence becomes more common, pharmacists need to supply remedies that are fast-acting to help ease pain the morning after."

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The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – phamlaw@cmpinformation.com – along with their full name and the name of their pharmacy. The latter two details are for C&D's records only – pharmacists' identities will be kept anonymous when the answers are published. All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

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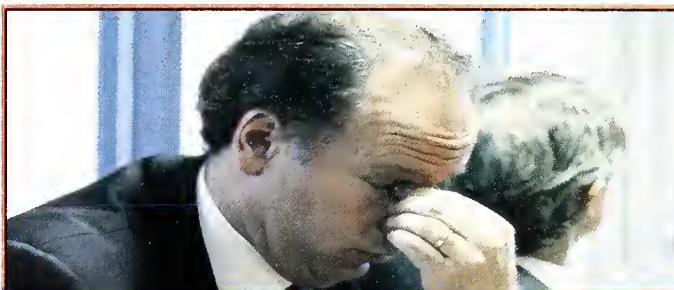


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The Belarus visitors were happy to accept the supplements

Vitamin boost for Chernobyl kids

UniChem has supplied 17 children, who live in a region of Belarus where 70 per cent of the radiation from the 1986 Chernobyl nuclear accident fell, with a year's supply of multivitamins.

The group visited the UK as guests of the Mid-Surrey Link of the Chernobyl Children Lifeline earlier this year. Pharmacist Parimel Amin was moved to make the offer of free supplements after attending a Rotary Club meeting at which Mid-Surrey Link

chairman Philip Taylor spoke, and asked his UniChem account manager Neel Singh if the wholesaler could help.

UniChem product manager Helen Price said: "The effect of the Chernobyl disaster on Belarus has had a real impact on the children's health and it is vital that they receive the vitamins that are lacking in local food. We were pleased to be able to provide multivitamins from our own-brand range."

What did the Romans do for us? Roads, baths... and beauty cream

The contents of a sealed Roman pot that was unearthed during an archaeological dig in London have been revealed to be... skin cream.

When it was uncovered last summer, initial guesses as to the contents of the container ranged from toothpaste to a mixture that was smeared on goats before they were killed. But a team of chemists from Bristol University has not only discovered the true nature of the product, but also recreated it from fresh ingredients.

Reporting in the journal *Nature*, the researchers said starch and animal fat each comprised around 40 per cent of the cream, with the remainder made up of synthetic

tin oxide. This was probably added as a pigment to hide blemishes and whiten the complexion, making the product an equivalent to modern-day foundations.

Although the cosmetic is thought to date from approximately 150AD, the tin box it was stored in meant it was very well preserved, enabling the scientists' analysis. The canister is currently on display at the Museum of London, and curator Francis Grew said: "It may be that we are looking at the equivalent of a Space NK product. The container is quite a classy piece of work as well; you're looking at quite a posh piece."



Comedian Richard Blackwood presented Lloyd'spharmacy commercial director Mark Green with the award at the British Diversity Awards ceremony last month

Lloyd'spharmacy TV ads win diversity prize

Lloyd'spharmacy has won a diversity award for its recent TV advertising campaign promoting the use of consultation areas.

The pharmacy chain was named 'The Gold Standard Champion for Best Diversity TV Advert in the UK' at the annual British Diversity Awards, held at the London Hilton, Park Lane on October 22. The awards celebrated the UK's multicultural society and recognised organisations and

individuals for their inclusive practice.

Accepting the prize from comedian Richard Blackwood, Lloyd'spharmacy commercial director Mark Green said: "The consultation areas provide a forum for all individuals to talk with our pharmacists in an environment that suits them, on a one to one level. We're delighted to be recognised as much for this service as for the commercial that represents it."

Owed to the compoota

For anyone requiring some light relief, Stuart McMillan of Kent LPC has sent in "a little poem two make u smile" entitled "Spell Chequer":

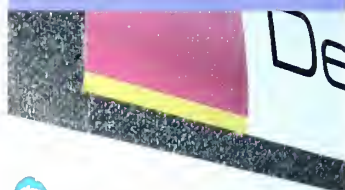
Eye halve a spelling chequer
It came with my pea sea
It plainly marques four my revue
Miss steaks eye kin knot sea.

Eye strike a key and type a word
And weight four it two say
Weather eye am wrong oar write
It shows me strait a weigh.

As soon as a mist ache is maid
It nose bee fore two long
And eye can put the error rite
Its rare lea ever wrong.

Eye have run this poem threw it
I am shore your pleased two no
Its letter perfect awl the weigh
My chequer tolled me sew.

In today's high security climate we are all prepared for the extra vigilance at airports. But sometimes it can be hard to follow the logic, as Devon LPC discovered en route to last week's PSNC conference in Manchester. Has there been a spate of people being threatened with paper cuts?



Our other poster is a glossy one - Confiscated at the airport!!

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A

Signature

Full name

Full pharmacy name and address

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1. This competition is open to any pharmacist or member of staff who works at an address which receives either Chemist & Druggist or Community Pharmacy. 2. Competitors may enter the competition in either Chemist & Druggist or Community Pharmacy, but may only enter once. Double entry will disqualify both. 3. Entries must be on an original coupon from Chemist & Druggist or Community Pharmacy, and to be eligible for the prize entrants must correctly answer the question on the coupon. 4. The prize offered will be as stated. No cash prizes or cash equivalents will be offered. 5. The names of winners will be published in Chemist & Druggist or Community Pharmacy. 6. In any dispute, the decision of the Pharmacy Group's publishing will be final and no correspondence will be entered into. 7. Employees of CMP Information Ltd, CMP International and trading divisions and immediate families are forbidden to enter. 8. No prize is necessary to participate. 9. The closing date for this month's competition is as printed on the coupon. 10. The prize is applied to CMP Europe Ltd and CMP Information Ltd. It will be shared with any member of the United Kingdom Media Group world-wide, associated companies and subsidiaries for the purposes of direct marketing, direct marketing or publication. It may also be made available to external parties on a rental or lease basis for the purposes of direct marketing. If you do not wish data to be made available to external parties on a list rental or lease basis, please contact the Data Protection Co-ordinator, CMP Information Ltd, Dept PHP649, FREEPOST LON 15637, Tonbridge, TN9 1BR or Freephone 0800 279 0357.

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